REPRESENTATIVE FOR
CHILDREN AND YOUTH

Housing, Help and Hope:
A Better Path for Struggling Families

July 2009

July 28, 2009

The Honourable Bill Barisoff
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria BC V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting *Housing, Help and Hope: A Better Path for Struggling Families* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of deaths and critical injuries of children receiving reviewable services. In this instance, the report deals with the June 17, 2007 referral made by the Select Standing Committee on Children and Youth.

Sincerely,

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Mr. E. George MacMinn, QC
Clerk of the Legislative Assembly

REPRESENTATIVE FOR
CHILDREN AND YOUTH

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REPRESENTATIVE FOR
CHILDREN AND YOUTH

Executive Summary

This Representative's Investigation examines a case in which the system of supports to vulnerable families failed, and the child protection system intervened in the most intrusive way – with shattering results. A young First Nations couple, willing and able to nurture their two-month-old boy, needed short-term assistance with housing. Despite discretion in the system to help them, they did not receive it.

There were reasonable grounds for the Ministry of Children and Family Development (MCFD) to initially get involved with this family. Reports were made to the ministry alleging child protection concerns arising from their temporary living arrangements with relatives.

The infant was removed from his parents' care on Sept. 19, 2006 following a finding of risk under the *Child, Family and Community Service Act* (*CFCS Act*).

The baby was hospitalized on Dec. 20, 2006, after one of his foster parents called 911. The injuries suffered by this child were profound.

The baby had been placed in three different foster homes, not connected to his culture or his community, in the first three months after being taken into care. After the injury, he was placed in a fourth foster home.

He was eventually returned to his parents' care in July 2007 under a supervision order.

In January 2008, the supervision order expired, was not renewed, and the child remained in the care of his parents with no further child protection involvement by the ministry.

After the baby's injury, the Crown commenced criminal proceedings against a foster parent, which were subsequently stayed. As well, the biological parents launched civil proceedings against MCFD and the foster parents. The civil proceedings are ongoing.

Today, at the age of three, the child has cerebral palsy, is blind in one eye, doesn't walk yet, and will need life-long supports.

Due to unforeseen, sometimes unthinkable circumstances, families can find themselves set adrift in a world abruptly strange and unaccepting, if family and friends are no longer a viable resource for a home. A "place of your own" is crucial to every family feeling protected and secure, and provides shelter, safety, privacy, an identity and a place to care for each other.

Yet in this case, these parents were put in a no-win situation – choose to stay with relatives and lose care of their son, or choose to keep their child and leave the security of staying with family – without having the money necessary to move out. In what world do we want that to be the best – or only – option for young parents wanting to keep their family together?

Unfortunately, no one stepped forward in a timely way to say "Here's how we'll help you address your short-term housing problem so you can keep your child safe." These young, inexperienced and stressed parents (the mother was 20 and the father 24 at the time the baby was born) were left to figure it out on their own, and because they couldn't, their son was taken away, a family broken apart.

A Representative's Investigation looks at these key questions:

- What happened?
- How and why did this happen?
- Has anything changed as a result of this?
- How can we prevent this from happening again?

There is a significant opportunity to learn from what happened to this boy and his family.

First and foremost, follow the *Child, Family and Community Service Act*. This law, and the policies and standards that give it life, are in place to support families, and ample direction is provided in the Act for temporary support for a family in need. The Act, service standards and policy direction are abundantly clear and adequate with one exception: in this particular case, the Delegation Agreement with the First Nations Agency does not provide the necessary clarity on roles and responsibilities. In conducting the investigation, the Representative notes that the roles and responsibilities of those serving the child's family were unclear.

Secondly, use discretionary funds to assist capable yet vulnerable parents to keep their families intact. This must be done through better alignment of service between MCFD, delegated agencies and the Ministry of Housing and Social Development (MHSD). The cost to society for child protection and foster home placements exceeds the cost of temporary housing.

As noted in the concluding section, our collective responsibility for the safety and well-being of all children, whether Aboriginal or non-Aboriginal, cannot and must not be divested. Nor can the responsibility be left in the hands of those who do not accept, understand or take seriously the full range of accountability for their actions. Agreements cannot be left unclear, and practice must not fall below standard.

The removal of children through the child welfare system appears to be the default approach that kicks in when other supports and services (emergency housing, transitional supports for families on the move) are not in place or are difficult to access.

At the centre of all investigations carried out by the Representative is the core question of: "How can we help prevent this from happening again?" Addressing this is both easy and difficult.

The easy answer is to use all available mechanisms in current legislation and policy to support vulnerable families in a way that addresses their needs. Be as flexible as possible in doing so, be accountable for outcomes and ensure that sound social policy and practice guides services. Ensure that strengths are recognized, as well as social factors such as poverty that can undermine those strengths. This means that income assistance, housing and child welfare systems need to be coordinated and work seamlessly, hand-in-hand, to support vulnerable families like the one at the centre of this investigation.

A difficult obstacle identified is the lost opportunity for learning in the child welfare system. Learning continues to be hampered by the nature of the ministry's audit, review and feedback loops.

Presently, the "Director" in each region controls the terms of reviews and the eventual content of the reports and their recommendations. Audits are signed off regionally. This really means that internal review processes become even more captured by internal interests and viewpoints.

MCFD has abolished the role of the Provincial Director of Child Welfare at its headquarters, and as a result an important set of checks and balances was lost. The office of the Provincial Director of Child Welfare was also an essential organizational catalyst and repository for system-wide learning. Even internal review processes benefit from fresh eyes and bigger-picture outlooks that take into account the larger context within which the child welfare system operates.

These issues undermine the effectiveness of the review functions which are so fundamental to the exercise of authority under the *CFCS Act* and the extension of learning to the direct practice staff.

The Representative does not make a recommendation specific to this in this report, because it was fully and completely addressed in Recommendation 5(A) and others under the "Case Reviews" section of *Amanda, Savannah, Rowen and Serena: From Loss to Learning* in April 2008. This recommendation remains unaddressed to the satisfaction of the Representative.

In this particular case, the Representative observes that the ministry's internal analysis did not meet the test of helping front-line workers. It resulted in a practice advisory of questionable impact. It did not encourage understanding of the broader issues. And it was of little value in promoting effective intervention across two key ministries with a duty of care for vulnerable children and families – MCFD and MHSD.

Introduction

Any examination of child protection issues must begin with recognition of the incredibly difficult job done by child protection workers and others on the front-lines of the system. The Honourable Ted Hughes, QC, in the *BC Children and Youth Review* rightly noted that "beyond the formal skills, the job requires toughness, warmth, intelligence, compassion, decisiveness and determination. It has been called the hardest job in government."

The Representative expresses deep appreciation to these strong and empathetic individuals, and to all who are doing such essential work for our children. This also includes the foster parent community, as critical injury investigations such as this also cause much concern and anxiety to them. These women and men who open their homes and hearts to children in times of need are so very deserving of our gratitude and respect, not only for the enormous responsibilities they bear but also for the positive influence they have in the lives of children.

Child protection workers and foster parents are involved with families in their most difficult times – often when homes, children and families are thrown into upheaval due to abuse, neglect or violence. We must genuinely give and often state our thanks to those who offer children protection, dignity and relief.

In a critical injury investigation by this office, the Representative is not examining whether the actions of individuals were ideal from our position looking backward, but whether they were reasonable in the circumstances at the time. We do this to ensure the enduring lessons for today's front-line workers are found, and that system improvements result from those lessons.

The Representative also thanks the parents of this boy for opening up about the painful details of this event, for this investigation. They hope, as does the Representative, that British Columbians may learn from their experience.

In this report, care has been taken to avoid identifying the boy and his family by name or location. This is out of respect for the child now and in his future, and for the ordeal his parents have been through. The Representative appreciates the need for this, and in turn requests that others respect their privacy. It is crucial to not impose more hardship on a young family that faces many challenges in the coming years, as they do their best to meet the trials of disability and to overcome a difficult history.

Methodology and Context

Legislative Context

On June 17, 2007, the Select Standing Committee on Children and Youth referred this case to the Representative for Children and Youth for investigation under Part 4 of the *Representative for Children and Youth Act* (*RCY Act*). The Representative determined that the case was appropriate for investigation. The matter clearly involved a critical injury, as it had the potential to result in the child's death or cause serious or long-term impairment to the child's health. Medical opinion after the injury suggested that the injury occurred in unusual or suspicious circumstances.

Based on available information at the time of the referral, the Representative determined that MCFD's involvement and decision-making pertaining to the child's removal and foster home placements warranted investigation.

In light of legal proceedings in the past or currently underway in this matter, it is important to distinguish between the function of the Representative and the function of a court in a criminal or civil case.

The Representative is not a court of law, does not apply legal tests of criminality or liability, and has no jurisdiction to make findings of legal fault. The fundamental purpose of the Representative's Office and Part 4 of the RCY Act is very different from that of a court. That purpose was concisely described in the *BC Children and Youth Review* (Hughes Review):

> ....In addition to any other investigations into a child's death [or critical injury] by police, a coroner or in legal proceedings, we have the right to expect that every suspicious or unexpected death of a child in the child welfare system be reviewed in a timely, thoughtful and impartial manner, with a view to learning lessons that can guide protection, parenting and care giving practice in the future, so that similar tragedies can be avoided.

The purpose is to see if there are lessons to be learned from an investigation by the Representative. This analysis is guided by a fair and realistic assessment of MCFD and public body practice – not by what is sometimes called "analysis by hindsight". Ministry child protection workers have to make very difficult decisions. Even the best practice and best analysis cannot predict the future with certainty, and it would be unfair to hold the ministry to impossible standards. The standard that is appropriate is that of a reasonable person applying policy and practice guidelines.

At the same time, it is precisely because of the profound consequences of child protection decisions that sound decision-making and best practice are so vitally important. The Representative's analysis is focused on those areas – best practice and reasoned decision-making grounded in the realities of the case.

To ensure that the Representative achieves the purposes articulated in the Hughes Review, the Act confers considerable investigative powers on the Representative. It also grants the maximum legal protection for persons giving evidence to the Representative. The Representative has a responsibility to produce a report balancing public accountability and privacy, while making recommendations to the appropriate public bodies or people.

Recommendations that are ignored or gather dust are of little benefit to anyone. For this reason, the Legislature has conferred a specific power on the Representative to "report [to the Legislative Assembly] on the level of compliance" with her recommendations. Considerable care is taken by the Representative to develop recommendations that are meaningful, focused and achievable.

Methodology

This investigation focuses on a five-month period – from July 28, 2006 (when the first child protection report about this infant was made to MCFD), to Dec. 20, 2006 (when he was admitted to hospital on an emergency basis.) During this period, the ministry responded to two child protection reports, removed the two-month-old child from his parental home, and supervised his care in a series of three consecutive foster homes.

Section 12 of the *RCY Act* outlines the basis for the Representative's investigations. It places the focus of investigations on services and circumstances preceding a critical injury. For this critical injury investigation, interviews were conducted with the child's parents, MCFD front-line staff and regional management, foster care providers, staff and management of the local delegated Aboriginal Agency, contracted agency workers, leaders of the child's First Nation community, and officials with the Ministry of Housing and Social Development (MHSD).

Interviews were conducted in accordance with Section 14 of the *RCY Act*, which allows the Representative to order witnesses to appear as part of a Representative's Investigation. Witnesses were sworn in and their evidence transcribed by a court recorder. Seventeen such interviews were conducted in the course of the investigation. In addition, informal inquiries were made as required.

Research and evaluation was conducted to deepen the understanding of the system of services and supports to vulnerable children, and to support analysis of how the system is meant to function, how it functioned in this instance, and how it might be improved to support better outcomes for vulnerable children.

A draft report was shared with the Representative's Multidisciplinary Team (see Appendix D), established under the *RCY Act* and Regulations "to provide advice and guidance to the Representative" respecting reviews and investigations. The team met, considered the draft report, and provided valuable input with respect to the analysis, findings and recommendations.

A draft was also provided to MCFD and MHSD for review and written comment regarding factual errors or omissions. The report or portions of it were also provided to other affected agencies and persons as appropriate for administrative fairness.

The Service Region

The child who is the focus of this report was removed from his parents' care by the ministry when he was an infant of about two months. The community he lived in, along with an adjacent rural area and some small towns, comprises a 'planning area' within one of the five ministry regions.

In September 2006, the month this infant was removed from the care of his parents, a total of 11 children were brought into government care from this planning area.

During that month, there were 15 children in care in this area under the age of one year, and 258 children and youth in care ranging in age from newborn to 19. Of these, 158 were children and youth in permanent care of the ministry.

In September 2006, there were 134 Aboriginal children and youth in care in the MCFD planning area where the child resided.

In that month, there were 9,159 children in care in the province. Of the 9,159 children, 4,657 were Aboriginal.

In September 2006, there were 110 foster homes within the planning area, with a total of 178 foster home beds. There were five Aboriginal foster homes, all restricted family care homes. (Restricted family care foster homes are approved to provide foster care for a child who is known or related to them. Often the foster parents are members of the child's extended family and they are restricted to providing care for a specific child or sibling group.)

At the time of this child's involvement with the ministry, there were five ministry resource social workers and one team leader working in the area of finding placements for children, and overseeing foster homes on an ongoing basis.

In fiscal 2006/07, the ministry spent $3.787 million on residential care for children in care in this planning area, and another $1 million on associated guardianship costs.

The Child's Community

The child who was critically injured lived on a reserve adjacent to an urban community. He is a member of a First Nation that participates with other local First Nations in governing a delegated Aboriginal Agency, which is described later in this report. The First Nation that the family belongs to has a present-day total population of approximately 1,600 people. Of these, about 700 people reside on-reserve in small communities in the general area, and about 900 reside off-reserve. About 70 of its children are currently in the care of the ministry, with a larger number served by child-serving agencies and supports. The particular reserve community that this family is from has an approximate population of 200.

Chronology

Investigations and Removal

The child was born on July 9, 2006 in Alberta, shortly after his parents moved there from their home in B.C. to look for work. When he was born, his mother was 20 and his father was 24. Both parents came from the same community in B.C. and were active in their First Nation community. The child's father often engaged in traditional harvesting activities and both parents participated in ceremonies and cultural activities of their Nation. The infant's parents had histories of involvement with the ministry during their childhood. One of the parents had been a child in care for a period of time.

Shortly after the birth, the young family moved back to their home community in B.C. and resided with the child's grandparents in their home on a First Nation reserve. Their cultural and family ties were a significant factor in their return after their first baby was born.

On July 28, 2006, a child protection report was made to MCFD. The child was 19 days old at the time. The person making the report expressed concerns about the child residing in his grandparents' home where another adult relative was also reported to be living. They also said there were historical child protection issues that involved the child's grandparents as well as the other relative and suggested that the residence was an unsafe home for the child.

The intake social worker who received the report reviewed the family's history in ministry files and found a number of prior child protection concerns reported to MCFD involving the grandparents and the other relative. The concerns involved alcohol use, neglect and physical abuse of children in the family.

The intake social worker also obtained additional background knowledge about the child's relatives from an investigating social worker who worked in the same office. The investigating social worker had been previously employed as contract legal counsel for MCFD. As counsel, the investigating social worker had become familiar with the history of some members of the child's family, and was aware that the other adult relative living in the home had previously been convicted for child-abuse related offences and assault in another jurisdiction, and that the adult relative's children were in permanent care of the ministry.

The intake social worker assessed the child protection report as needing an immediate response. An MCFD social worker and a social worker from the delegated Aboriginal Agency visited the residence together on July 28, 2006 and no one was home. The MCFD social worker visited the residence for a second time on the same day and again no one was home. On a third visit to the residence the following day, the social worker spoke to the family regarding the concerns that had been reported to MCFD.

The MCFD social worker explained to the child's father that the child could not reside in that home due to the child protection concerns involving the relatives. The mother joined the discussion and the social worker said that she appeared to acknowledge the ministry's concerns. The social worker inquired about other relatives that the family could reside with in order to minimize the risks to the child. The social worker told the parents that the child would be removed if alternate arrangements weren't made. The social worker and the mother agreed on an immediate safety plan, for the mother and the child to stay with another relative who lived in a different community.

The child's ministry file was transferred to another MCFD social worker on Aug. 1, 2006. This worker had been a child protection social worker with the ministry since 2004, having worked on the local Aboriginal family services team and on the non-Aboriginal family services team. She had transferred to the investigations team approximately one month before the first protection report was made.

On Aug. 1, 2006, this investigating social worker and a social worker from the delegated Aboriginal Agency conducted a home visit to the residence of the relative of the mother, where she had arranged to reside. They were informed that the child and his parents had stayed with these relatives during the weekend, but had since left to stay at the home of a different relative.

The MCFD and delegated Aboriginal Agency social workers attended that residence and met with the parents. The child looked well and both of his parents were attentive to their baby. The father told the social workers that he had a lawyer and that he did not have talk to them. The social workers explained that their safety concerns arose from the child living in his grandparents' residence and the concerns could not be resolved because the residence was determined by MCFD to be unsafe, due to historical child protection concerns.

The child's mother said that she understood the social workers' concerns. She said that for the time being, they planned to reside with a close relative while they were looking for off-reserve housing as no housing was available on reserve, apart from sharing with extended family.

She was eligible to receive social assistance from her band, as long as she resided on-reserve, but there were no on-reserve homes available. To address the child protection concerns raised by the ministry, she would need to secure accommodation off-reserve. Financial assistance for individuals living off-reserve was provided by the Ministry of Employment and Income Assistance (MEIA), now known as the Ministry of Housing and Social Development (MHSD).

The MCFD social worker conducted a search for any previous child protection concerns involving the identified relative's home and no concerns were noted.

The ministry received another call three days later, reporting that the parents had returned with the child to the grandparents' home. In response, the MCFD social worker consulted with the acting team leader. Because the social worker had previously determined that the parents were adequately protecting the child's safety, and also because the parents planned to reside with relatives only until financial assistance and off-reserve housing was secured, the acting team leader directed the social worker to close the file and not respond to this report. The child protection file was then closed.

On Aug. 8, 2006 the mother contacted MEIA to apply for income assistance. The mother indicated that she was living temporarily on-reserve with a relative and was seeking permanent off-reserve accommodation in order to address the ministry's child protection concerns regarding relatives.

The MEIA worker advised the mother to call back in three weeks, with a completed Intent to Rent form, documentation to indicate she had found accommodation off-reserve (eligibility for the provincial financial assistance program is restricted to individuals and families living off-reserve). The employment assistance worker informed the mother that her application for income assistance would be considered after the three-week period and that she was not eligible to receive financial assistance during that period.

On Sept. 14, 2006, another child protection report was made to the ministry. The person making the report told ministry staff that another adult relative had been seen walking alone with the child in his stroller and suggested that this man had been residing in the grandparents' home with the child and his parents. This man was known to the ministry due to previous allegations of sexually inappropriate behaviour.

The child protection report was assessed as requiring an investigation and transferred to a child protection investigating social worker. The investigating social worker who received the file had been employed by the ministry since 2004. Upon receiving the file, she consulted with her supervisor, with the delegated Aboriginal Agency social worker and with the social development officer from the First Nation to determine the process of her investigation.

The investigating social worker learned about the child protection concerns involving this relative through the ministry's electronic case information system. She also had prior knowledge of the concerns related to this man from her colleagues. There was no information on the system indicating that he had been convicted of a sexual offence, but the social worker noted that an alert had been placed on the system with regards to a number of allegations that had been brought to the ministry's attention. The worker could

not recall whether she had made an effort to obtain further information from the RCMP regarding the allegations, at the time of her investigation.

The Representative's staff reviewed MCFD's information system as part of the investigation and identified the alert on the system. However, information was found for only one allegation, which had been reported during the period of time between the first and second child protection reports regarding the baby, and was later recanted.

The investigating social worker's notes indicated that she had received multiple reports from individuals that claimed to have witnessed the child in the unsupervised care of this relative. None of these reports were documented in the electronic system. Apart from the caller's report, there was no verification of the child's identity.

The investigating social worker concluded her investigation on Sept. 19, 2006 and found that the child was still at risk of harm by exposure to high-risk relatives with unsupervised access to him. She determined that the child was in need of protection. The investigation findings (as per Section 13 of the *Child, Family and Community Services Act*) were documented on the system as "parent not protecting from abuse and likelihood of neglect by parent with physical harm".

The investigating social worker consulted with her supervisor and discussed the most appropriate response. Less intrusive measures, such as a supervision order, were not considered a viable option due to the "isolated nature of the reserve" and the ministry's concerns regarding unsuccessful efforts to keep the infant away from certain relatives.

After consulting with her supervisor, the investigating social worker decided to remove the child from his parents' custody and take him into care of the ministry. The MCFD social worker contacted the delegated Aboriginal Agency and requested that a social worker from the Agency meet her at the reserve for the removal.

Under the Delegation Agreement of the day, this Agency was delegated at level C12 and 13, which means that it did not have the delegated authority for child protection services or removals of children, but did have the delegated authority with regard to providing support services to families, voluntary care agreements and recruiting, and assessing and supporting residential resources for children in care. These functions are defined in the Aboriginal Operational and Practice Indicators and Standards (AOPSI). Those standards further require that the Aboriginal Agency have a protocol agreement in place which addresses how the Agency will work with other agencies, including MCFD. It is also intended to define the "roles of the social workers, supervisors and management in the assessment, planning, delivery and monitoring of services" (AOPSI Standard 27).

Delegated Child and Family Service Agencies

The ministry has a variety of initiatives underway to address the number of Aboriginal children in care. This includes the development of agreements between the province and First Nations communities to return historic responsibilities for child protection and family support to Aboriginal communities. These agreements are known as delegation agreements.

Through delegation agreements, the Province gives authority to Aboriginal agencies, and their employees, to undertake administration of all or parts of the *Child, Family and Community Service Act* (*CFCSA*). The amount of responsibility undertaken by each agency is the result of negotiations between the ministry and the Aboriginal community served by the agency, and the level of delegation provided by the Director.

Source: Ministry of Children and Family Development
www.mcf.gov.bc.ca/about_us/aboriginal/delegated/index.htm

On Sept. 19, 2006, on the way to the reserve, the delegated Aboriginal Agency social worker called the ministry to inform them that the Agency had a foster caregiver available to care for the child after they removed him from the care of his parents. The delegated Aboriginal Agency social worker reported that she did not receive a response from the ministry until one or two days later when she was informed that the child had already been placed in a non-Aboriginal foster home.

The social workers from the ministry and the delegated Aboriginal Agency had attended the reserve to remove the child, so it is unclear as to why the delegated Aboriginal Agency social worker would not have known of the decision about where the child was going to be placed. As noted earlier, under the Delegation Agreement in place at the time the child was removed, the Agency had an important role in providing support services to families living in the community and in developing foster homes. While the Agency did not have decision-making authority about the placement of the child, the AOPSI standards in effect at the time contain multiple references to placement planning, involvement of the Aboriginal community, and services to families.

The delegated Aboriginal Agency social worker and the investigating ministry social worker attended the reserve and met with an RCMP officer. They found the infant's mother walking with him in a stroller. The social workers told her of the reported concerns that she was living in the grandparents' residence with her child and allowing access to her child by another relative about whom concerns had been raised.

The child's mother told the social worker that they had been residing in the residence with the child for the past week, due to economic necessity. The mother also explained that she had been in the hospital for the past week and that the child had resided with his father in the residence at that time because there was no other option.

The social worker explained to the mother that she was going to remove the child from her care. The mother was cooperative and gathered up the child's belongings for the social workers. The child was then taken from his mother's care.

The day after the baby was removed from his parents he was examined by a physician and assessed to be a healthy baby.

According to leaders of the child's First Nation, MCFD was supposed to fax notification to the band office whenever ministry staff removed a child from reserve land. First Nation leaders do not recall that such a notification was received at the time of this child's removal. MCFD social workers said that notification was often provided in-person by a social worker who was attending the reserve to remove a child.

Planning and Foster Care

An MCFD foster home resource worker contacted a couple who were experienced foster parents. The worker told them that a foster placement for the child was urgently needed. The caregivers agreed to foster the child on a short-term basis. The ministry drafted a 30-day contract for the child's placement in the home. At the time, they were already fostering a 1 ½-year-old girl.

Foster Home Placement Process

The resource social worker and the supervisor of the resource unit in the office in Sept. 2006 described the process used by that office to locate a foster home when one is needed. They indicated that this was the process used to place the baby who is the focus of this report.

When a child is removed from the custody of the parents, the child's social worker will make direct contact with a resource social worker, who is the social worker for specific foster homes. During the conversation, the resource worker will complete an intake form, which is a document that includes information regarding the child's family and medical history. The purpose of the intake is for the social worker and resource worker to best identify the child's needs and match the child's needs with the most appropriate foster home. The intake form is referred to throughout a child's time in care of the ministry.

The resource workers meet weekly to review and discuss the intakes and follow-ups required for children who have come into care. This consultative process can also take place between the supervisor and individual resource worker if there are specific issues to discuss. The resource worker and supervisor from the office that placed this child reported that weekly meetings occurred on a regular basis, as well as specific case consults between the resource worker and his supervisor, as needed.

When the child is Aboriginal, the resource worker will contact the delegated Aboriginal Agency for the area, to determine whether they have a foster home available for the child. If the Aboriginal Agency does not have an available home, the resource worker will look for a foster home within the MCFD region.

The child was placed in that foster home the same day he was taken into care. His ministry file was then transferred to the ministry's Aboriginal family service team. The Aboriginal family service team provides services to on- and off-reserve Aboriginal children and families within a specific geographic area. The social worker who received the child's file had been a social worker on the Aboriginal family service team since 2005.

The MCFD social worker's Sept. 19, 2006 case notes, the day the child was taken into care, indicate that a relative of the child was interested in fostering the child. This person operated a regular foster home at the time. Follow-up information related to this relative was not found in the file and the outcome of the request is not known.

The following day, the social worker from the MCFD Aboriginal family service team met with the parents to discuss the names of relatives who may be able to provide care for the child while he was out of his parental home. The parents provided the social worker with the names of two family members. The social worker said she made attempts to contact those family members but did not receive a response. According to the parents, the family members were not contacted by the social worker. This investigation did not resolve this conflicting information.

A comprehensive risk assessment dated that same day was signed by the social worker who had removed the baby. The assessment rated him at high risk of harm overall and identified a lack of suitable housing, overcrowded living conditions and the parents' recent move and separation as factors contributing to the child's risk of future harm. (The parents were temporarily separated at this time because there was not enough room for them to all stay together.) It was also noted that the parents continued to allow access to the child by relatives who had histories including child abuse and neglect issues.

The social worker noted that the mother had indicated that she had been trying to locate accommodation since July in accordance with the ministry's expectations but the worker was unclear as to how much effort had been made.

Following the risk assessment, a risk reduction service plan was completed. It identified the following strategies to decrease the risk of harm to the child:

- referral to a program to help set healthy boundaries with extended family members
- assistance in locating accommodations
- family therapy to deal with family of origin issues
- parental support groups
- parental capacity assessment

According to Children in Care Service Standard 11: "Assessments and Planning for a Child in Care", an initial plan of care for the child was to be completed within 30 days of the child being brought into care of the ministry. An initial plan of care should have included:

- the long-term goal for the child
- plan for contact with the child's family and community
- services required to fulfill the plan
- strategies for the child to remain involved in social, recreational and spiritual activities

The child's social worker did not complete an initial plan of care for the child.

A presentation hearing is a court hearing that is held within seven days following the removal of a child from parental care. The purpose of a presentation hearing is for a judge to decide whether it would be in the best interests of the child for MCFD to have interim custody of the child, pending a protection hearing to determine whether the child is in need of protection. If the court concludes at a presentation hearing that it would be in the best interests of the child for the ministry to have interim custody, the court will set court dates to make decisions about the child's custody.

A presentation hearing was held for this child on Sept. 26, 2006. The social worker who removed the child testified that she would consider returning the child to the care of his parents "provided [the parents] could come up with living arrangements that the ministry deemed were safe and suitable for [the child] to be returned." The social worker also stated that a member of the child's family had come forward to care for the child and that the ministry was considering the relative as a potential caregiver. It is not clear whether this family member was the same family member that had been suggested by the parents. The RCY Investigation found no documentation relating to any follow-up with this potential caregiver.

The social worker testified that the interim plan of care for the child was that he would remain in the foster home while MCFD looked into a family placement, and that he could possibly be returned to his parents' care under a supervision order, if his parents found a suitable place to live. At the conclusion of the presentation hearing, the judge granted an interim custody order of the child to MCFD.

On Oct. 2, 2006 the social worker completed a referral to family group conferencing (see definition below) for the parents. The parents did not follow up on the referral. They said that they felt it was not an appropriate process to engage in because the ministry was saying that "all or most of my close family is a risk to my son".

Family Group Conferencing

The family group conference, which is also known as family group decision-making, is one type of shared decision-making process for families who are receiving child welfare services. It is a formal meeting where members of a child or youth's family come together with extended family, close friends, and members of the community to develop a plan for the child. A family group conference coordinator helps families to identify and invite people who will support them in developing a plan for their child. Family group conferences are designed to promote cooperative planning and decision-making and to enhance a family's support network.

Source: Ministry of Children and Family Development
www.mcf.gov.bc.ca/child_protection/mediation.htm

The risk reduction service plan for the child's care was finalized Oct. 11, 2006 by the Aboriginal family service team social worker. The plan identified a lack of housing, overcrowding, and the recent move back to B.C. as key factors which placed the child at risk of harm. The plan suggested the involvement of a family support worker for the parents to help find accommodation for them and the child.

In the service plan, it was noted that the father felt strongly that the child should have some contact with one of the adult relatives the ministry felt was unsafe. The father felt it was important for his son to know his family and his history.

The baby's first foster parents had been foster parents for 34 years. MCFD had designated their home a Level Two foster home (see description of foster home categories on page 21). The resource worker and supervisor both considered this to be a strong foster home.

During the child's stay in this foster home, the foster parents reported him to be a happy baby who often slept for 12 hours at a time, ate well, laughed and interacted well. They said he was overweight for his age, and required extra support for his head when he was being carried because he could not hold his head by himself. The foster mother said she had difficulty handling him due to his size. They reported there was nothing unusual about his behaviour or disposition during the time he was in their care.

The contract for placement of this child between the ministry and the first foster parents expired and the child was moved to his second foster home on Nov. 1, 2006.

The child's second foster parents were Métis. They were experienced caregivers and were regarded by the resource worker and supervisor as a strong care-giving resource. Their home was designated by MCFD as a Level Two foster home, and they were also fostering two siblings, aged 10 and 12 at the time.

During the child's stay in this home, he was reported by the foster parents to be a happy baby who rarely cried and slept 12-13 hours per day. The foster mother thought the child ate a lot and she was concerned he was slow in developing movement. She thought the child's upper body was disproportionately heavy and that if he was not seated appropriately his head could flop over because his neck muscles were not strong enough. There is no indication that this concern was followed up with a health care practitioner.

The foster parent also said she thought the baby's weight may have contributed to his slower development, but that his development was not significantly behind other children she had cared for. She suggested to the child's social worker that the child should be seen by the Child Development Centre in order to build up his lower body strength. There is no indication that this happened.

While the child was in foster care, the parents had regular visits with him on weekdays. In November, the mother reported that she was not able to visit regularly with the child

because she had begun working full time, in order to earn money so that she could afford suitable accommodation and her baby could be returned to her care. On November 9, 2006 the child's mother approached MCFD to request that her son be returned to her custody because she had found shared accommodation. The ministry rejected her request. They said that in a shared accommodation setting, there would be no way to guarantee the child's safety from high-risk individuals who may share the residence.

On Nov. 14, 2006, the MCFD social worker faxed a referral to an Aboriginal family service agency that provides services under contract to the ministry. The agency had been a ministry contracted service provider since 2003.

The social worker's referral requested a family service worker to help the parents address the risks identified in the comprehensive risk assessment and risk reduction service plan. The referral consisted of a summary of the mother's information, taken from the ministry's electronic case information database, and a three-page Referral Form for Protective Family Services. Only one page of the Referral Form was completed, and the other two pages were left blank. The completed portion listed the ministry's expectations for the parents:

- a program to help set healthy boundaries with extended family members
- assistance in locating accommodations suitable for the child
- family therapy to deal with family of origin issues
- parental support

The family service worker from the agency began working immediately with the parents to address the risks identified by MCFD.

On Nov. 17, 2006, the ministry was notified that the child's second foster mother was facing an unexpected illness and that an alternative placement would be needed. The resource worker considered placing the child back into the first foster home. However, due to the physical challenges in handling the child identified previously by that foster parent, the resource worker did not place the child back there.

On Dec. 8, 2006, an MCFD resource worker contacted another foster parent couple and asked that the child be placed in their foster home.

On Dec. 14, 2006, the social worker from the Aboriginal family services team and the team's supervisor visited the home of the child's grandparents. They discussed returning the child to the care of his parents under a supervision order. A family member at the home, who was a foster parent for the delegated Aboriginal Agency, volunteered to care for the child on weekends.

The Third Foster Home

The third foster parents of this baby had provided foster care for 38 children from January 2000 to December 2006 inclusive.

One of the foster parents had been approved as a restricted foster parent in November 1999, when she applied to be the caregiver for the daughter of her former spouse.

In 2002, she and her current spouse were approved by the ministry as a regular foster home. She was a stay-at-home parent while her partner worked outside of the home. The approval process involved a foster home study, criminal record checks, references and medical reports completed for each parent. The ministry completed annual reviews on the home in 1999 and yearly from 2001-2006.

File information indicates there was occasional tension between these foster parents and MCFD. In 2003, the foster parents were denied a change in designated rating from a Regular home to a Specialized Level One home. At that time the foster parents also informed their MCFD resource worker that they were experiencing financial challenges.

Foster Home Categories

Foster homes are categorized as Regular, and Specialized Level One, Level Two and Level Three foster homes.

Regular homes are an approved family who provide care for up to six children in care of varying ages and usual developmental needs. For 2009, regular foster homes are paid $803.82 per month per child for children age 11 and under, and $909.95 per month per child for children age 12 to 19.

Specialized Level One homes are an approved family who provide care for up to six children in care who have multiple developmental needs and who may have some challenging behaviours. For 2009, Level One homes are paid the Regular rates as indicated above, plus an additional $458.02 per month per child.

Specialized Level Two homes are an approved family who provide care for up to three children who may have more complicated developmental needs and more complex health needs. Level Two foster caregivers may also provide specialized assessment and intervention services as a member of the child's care team.

Payment for a second or third child placed in a level two home is based on a declining payment structure which reflects a decrease in service received with each additional child in the foster home.

For 2009, Level Two foster homes receive the following rates in addition to the rates paid to regular foster homes, as indicated above:

One child in the home: $1140.40 per month
Two children in the home: $1968.68 per month
Three children in the home: $2692.92 per month

Specialized Level Three homes are an approved family who provide care for a maximum of two children in care. Children placed in Level Three homes have care needs similar to those placed in Level Two foster homes. The children require extensive daily care including interventions related to mental health and behaviours that require additional support and supervision. Level Three foster caregivers may also provide specialized assessment and intervention services as a member of the child's care team.

Payment for a second or third child placed in a level three home is based on a declining payment structure which reflects a decrease in service received with each additional child in the foster home.

For 2009, Level Three foster homes receive the following rates in addition to the rates paid to regular foster homes, as indicated above:

One child in the home: $1816.66 per month
Two children in the home: $3113.12 per month

Source: Ministry of Children and Family Development
www.mcf.gov.bc.ca/foster/levels/htm

The designated level of each foster home reflects the specific skills, experience and training that approved caregivers have completed. Approved foster caregivers participate in an assessment and approval process to achieve designation at a specific level.

Criteria for designation of specialized foster care homes include:

1. Level of the caregiver according to the specialized family care home assessment and checklist
2. Capacity and willingness of the caregiver to meet service expectations at the recommended level of care
3. Area/regional needs and available homes
4. Regional resource plan and budget

Source: Standard 3, MCFD Caregiver Support Standards

In 2004, the couple again expressed interest in becoming a specialized foster care resource. They were advised that other foster homes were higher priority and that the ministry did not have funds available to support approving their home as a specialized foster care resource. The file indicated that a third discussion on this issue took place in 2005, and that the foster parents indicated they wanted to stop fostering as a result of the difficulties they experienced with MCFD. However, they continued fostering.

In November 2005, for the fourth time, the foster parents were denied a change in designated rating. File information indicates that the ministry informed the couple that the decision was due to budgetary restrictions.

At the time the resource worker approached this third set of foster parents about fostering the child who is the focus of this report, they were preparing for the upcoming Christmas holiday and had planned a large family gathering in their home. The couple was also fostering two other children: a five-month-old high-needs infant who had been born addicted to substances, and a 2 ½-year-old boy.

The foster parents were also being considered by the ministry for an adoption of a different child. This made them hesitant to agree to foster this baby because they felt that he may have to be moved to a different foster home if the adoption process was successful, and they were aware that their home would be his third foster home in less than three months.

The couple had been approved as a Level One foster home approximately one month prior to the request to foster this child. The Level One increase was effective Dec. 1, 2006. According to the foster parents, the resource worker indicated to them that they were obligated to foster the child because their foster home had recently been increased from a Regular foster home to a Level One home. The resource worker did not recollect having said this. He said that he would not pressure foster parents to take another child if they were not comfortable doing so. He said that they agreed to foster the child because he had appealed to them for their help and they had a good, long-standing working relationship. The couple agreed to foster the child and the child was placed in their home on Dec. 12, 2006.

File information indicates the ministry was considering returning the child to his parents under a supervision order on Dec. 19, 2006, despite the parents not finding accommodation that met the ministry's expectations for them to care for their baby. However, there is no follow-up information to indicate what the anticipated outcome would be, if such a plan were to be put in place.

The foster parents described the five-month-old child as "one of the easiest babies" they had ever cared for. They also reported that he could not sit up by himself and could not hold his head up.

On the evening of Dec. 18, 2006 the child's parents had a supervised visit with the child at a band Christmas party. A band health worker transported the child from the foster home to the reserve for the party at approximately 3:30 p.m. The band worker noticed that the child appeared to be cranky and not feeling well when he was picked up to be taken to the party. The child was in the supervised care of his parents until the band health worker transported him back to the foster home at approximately 7 p.m. that evening.

Circumstances of the Critical Injury

The Dec. 19, 2006 case notes of the child's social worker indicate that during a telephone conversation one of the foster parents said that the child appeared to be not feeling well and had thrown up the entire contents of his bottle that afternoon. Notes of the conversation also indicate that the child was sleeping for 13 hours without waking.

(The following reflects the circumstances of the critical injury as reported to the RCY investigators by the foster parent who was taking care of the baby the night he was sent to hospital).

Late in the afternoon of Dec. 20, 2006, the baby was home with one of the foster parents, while the primary foster parent was out shopping. The caregiver fed him a bottle and noticed that he became fussy shortly afterward, and placed him in his bed and heard him make a strange noise a few minutes later.

She returned to where the baby was lying down and picked him up. She noticed that he was fussy, but that he had not thrown up. The caregiver reported that she took him into the living room and held him on her lap, holding his chin up because he could not hold his head up by himself. She patted him on the back and then placed him in a "command centre". (The command centre is an immobile play centre in which the child sits in a seat and is supported to stand up. While supported, the child can manipulate various toys attached to the rim of the structure.) After placing the child in the command centre, the foster parent returned to the kitchen.

The foster parent said that a few minutes later she heard the child throw up. She went into the living room and noticed the child in the command centre with his arms spread out in front of his body and his head hanging down. She took him out and rested him on his side against her leg, because she knew that he had not vomited the entire contents of the eight-ounce bottle she had fed him a short time before.

The foster parent then took the baby into the bathroom, ran the bathwater, removed his clothing and placed him in the tub. She noticed that his body suddenly became stiff and his legs straightened.

The foster parent laid him beside the tub on a towel, and then picked him up and took him into his room, and laid him on the floor between her legs. She dried him off, and noticed

him making little moaning noises. She rolled him onto his side, and removed the towel. As she went to lay him back down, his body went limp.

She picked him up and held him close, patting him on the back, talking to him. She ran to the phone, and phoned the primary foster parent and reported that there was something wrong with the child. The primary foster parent said she would come right home. Shortly after she called the home and asked if they should call 911. The caregiver at home said no, and urged the primary foster parent to return home. She said that she felt that her partner would know what to do when she arrived home, and that as soon as the primary foster parent returned home, everything would be fine.

The primary foster parent arrived home a few minutes later and contacted 911. Emergency personnel attended the home and transported the child to the hospital.

Hospital records indicate that on arrival at the hospital, the child was examined by a pediatrician who reported that the initial concern was "an acute neurological emergency with increased intracranial pressure, possible traumatic brain injury." The child was also having seizures at the time and the hospital performed two spinal taps to test for encephalitis (which proved negative).

The child was transferred to BC Children's Hospital, where physicians determined that the child had extensive bilateral retinal hemorrhages, which raised the possibility that the injuries were non-accidental. An MRI revealed hemorrhages and moderate brain swelling with significant bilateral cortical damage.

Hospital physicians determined that the child's injuries were consistent with the child having been shaken. They determined that the injuries had likely resulted from a single event which had occurred sometime between the evening of Dec. 19 and shortly before his arrival to hospital on Dec. 20, 2006. During that period of time, the child had only been in the care of his foster parents. However, another medical opinion places the likely timing of the injury in a broader range of time.

Criminal Charges

The circumstances surrounding the child's admission to hospital resulted in a criminal investigation by the RCMP. On Dec. 29, 2006, Crown laid charges of aggravated assault against the caregiver who was home alone with the child on the evening of Dec. 20, 2006. The Crown stayed the criminal charges in April 2008.

The assessed timeframe of the child's injury led to the removal of the other foster children from the foster home on Dec. 29, 2006. On Jan. 4, 2007, the ministry initiated an investigation of the home, which was completed on April 23, 2007. The investigation recommended that the foster home be closed due to the criminal charges and seriousness of the child's injuries.

Shaken Baby Syndrome

SBS/AHT (shaken baby syndrome/abusive head trauma) is a term used to describe the constellation of signs and symptoms resulting from violent shaking or shaking and impacting of the head of an infant or small child.

When a baby is shaken, the brain rotates within the skull cavity, injuring or destroying brain tissue. Blood vessels feeding the brain may be torn, leading to bleeding around the brain. Blood pools within the skull, sometimes creating more pressure within the skull and possibly causing additional brain damage. Retinal (back of the eye) bleeding is very common.

SBS/AHT is recognized as the most common cause of mortality and long-term disability in infants and young children due to physical child abuse. If a baby survives being shaken, long-term consequences may include learning disabilities, physical disabilities, visual disabilities or blindness, hearing impairment, speech disabilities, cerebral palsy, seizures, behaviour disorders and cognitive impairment.

Often, perpetrators shake an infant or child out of frustration or anger. This most often occurs when the baby won't stop crying. Other triggering events include toilet training difficulties and feeding problems.

Source: National Centre on Shaken Baby Syndrome, www.dontshake.org

Subsequent Events

The Representative's Office was also involved with this child after December 2006, in relation to the Representative's capacity as an advocate for ongoing services. This report does not detail the advocacy efforts of the Representative on the infant's behalf.

The child remained in BC Children's Hospital until Jan. 12, 2007 when he was transferred to the hospital in his community. On Jan. 19, 2007, the child was discharged from hospital and placed into his fourth foster home, which was a specialized Level Three foster home. He was returned to the custody of his parents in July 2007 under a six-month supervision order.

The child began receiving support through Community Living BC in October 2007. In January 2008, the supervision order expired and MCFD did not pursue another order. In November 2008, the family moved into a subsidized housing unit, where they continue to live.

An August 2008 assessment indicated that a number of long-term physical and developmental consequences resulted from this boy's injury. The child had decreased hearing on his left side and right-eye visual impairment which required him to wear an eye-patch for one hour per day. The child was also diagnosed with epilepsy and cerebral palsy.

The previous medical assessment, done on Sept. 20, 2006 after the baby was removed from his parent's care, indicated none of these conditions and showed him to be a healthy baby.

Despite the child's complex medical conditions, the August 2008 assessment noted that he had demonstrated some developmental gains. He was becoming increasingly vocal and could manoeuvre himself into a sitting position, sit on his own and commando crawl. In December 2008, his parents reported that he was attending day care, and at age 2 ½, was getting around by crawling, but could not yet walk.

His long-term developmental circumstances are not completely clear but the impact of the injury is likely lifelong.

The child's parents feel he is showing some improvement. However, the fact that his injury resulted in cerebral palsy, epilepsy, and significant sight and hearing impairment means the child may face serious physical, developmental, educational and social challenges in the years ahead, and may require specialized medical care, treatment and support to cope with those challenges.

Timeline of Significant Events

2006

July

August

September

July 28

The first protection report regarding child received by MCFD. Intake assessed for investigation and followed up by MCFD social workers. Investigation found child's parents were adequately protecting his safety. MCFD file closed on August 3, 2006.

August 8

Child's mother first contacts MEIA to begin the application process for income assistance. Employment assistance worker informs mother she is exempt from job search requirement but required to wait mandatory three-week period before application can proceed. Mother advised to call back at end of the waiting period. Mother not assessed as having an immediate need.

September 14

Second protection report received by MCFD regarding the child. Intake assessed for investigation.

September 19

- Investigation found parents not adequately protecting child. Child removed from care of parents and placed in a foster home.
- MCFD called MEIA to inform that child had been taken into care. MCFD advised MEIA of child's removal to ensure the child's mother would not apply for income assistance for the child as well.

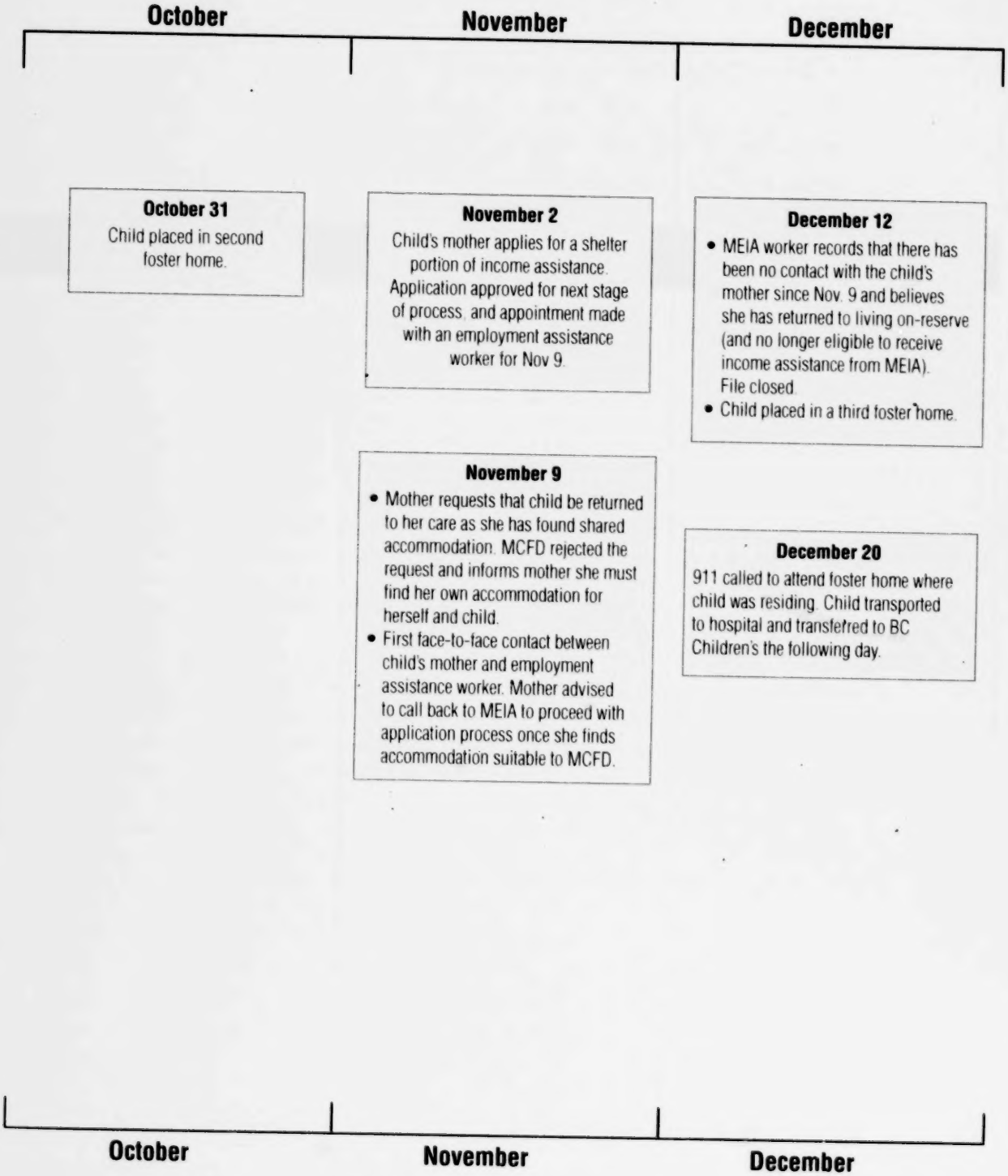
September 20

Medical screening by physician indicates child is a normal, healthy infant.

July

August

September


October
November
December
October 31
Child placed in second foster home.
November 2
Child's mother applies for a shelter portion of income assistance. Application approved for next stage of process, and appointment made with an employment assistance worker for Nov 9.
November 9
• Mother requests that child be returned to her care as she has found shared accommodation. MCFD rejected the request and informs mother she must find her own accommodation for herself and child.
• First face-to-face contact between child's mother and employment assistance worker. Mother advised to call back to MEIA to proceed with application process once she finds accommodation suitable to MCFD.
December 12
• MEIA worker records that there has been no contact with the child's mother since Nov. 9 and believes she has returned to living on-reserve (and no longer eligible to receive income assistance from MEIA). File closed
• Child placed in a third foster home.
December 20
911 called to attend foster home where child was residing. Child transported to hospital and transferred to BC Children's the following day.
October
November
December

MCFD Comprehensive Case Review

Following disposition of the criminal charges, the ministry undertook an internal Comprehensive Case Review which was initiated "due to severity and circumstances of the child's injuries". This review was completed October 20, 2008.

The Terms of Reference were as follows:

1. Were the responses to the child protection reports received in this case and the investigations conducted consistent with legislation, policy and service standards?
2. Was the care provided to the child after his removal consistent with the legislation, policy and service standards?
3. Were the foster parents recruited, trained, monitored and supported according to the legislation, policy and service standards?

The methodology of the MCFD review included review of files, including the files on the foster home and files involving extended family and some historical files related to the family. Ministry and delegated Aboriginal Agency staff were also interviewed.

With respect to responses to the child protection reports, the review found that they were "generally consistent with legislation, policy and did, for the most part, meet service standards; however all required steps were not always taken during the course of investigations". The review found that all "relevant and necessary information related to the report, including existing case records and files was not undertaken". It was also noted that more information could have been obtained about the family and child from people who knew them.

The review found also that "the care provided to the child after his removal was not fully consistent with legislation, policy and service standards". Concerns were noted in that requirements to work in partnership with the child's Aboriginal community or a delegated Aboriginal Agency in choosing a suitable placement were not fulfilled. Concerns were also noted in respect to the instability created by the child being moved. The child lived in three different foster homes within a three-month period.

The third major finding of the review was with respect to the foster home the child was living in when the injury occurred. The reviewer found that "the recruitment process and management of the foster home was generally consistent with the applicable legislation, policy and service standards. Aspects regarding the assessment process, training requirement and monitoring of the foster home were not fully consistent with the applicable policy and service standards".

Concerns raised in the review related to the 2002 Home Study. Although written references were collected as required, personal references were not interviewed in person or by telephone per policy guidelines.

The other concern was that in-person meetings between the resource social worker and the foster parents did not always occur quarterly as required by policy. However, regular communication between the worker and the foster home did occur.

Overall the comprehensive case review found that "Generally, the ministry's responses to child protection reports and the services provided to the family were consistent with the applicable policy and service standards".

The review resulted in two recommendations, which were expressed as goals, and associated strategies:

Summary of MCFD Comprehensive Case Review

The first goal was that "(MCFD regional) staff will consistently conduct their casework with aboriginal families as stipulated under the *Child, Family and Community Services Act*, specifically but not limited to Section 3.b. aboriginal people should be involved in the planning and delivery of services to aboriginal families and children".

Strategy 1 was that "The Community Services Manager will review with the Resource Services Team the intent, importance and requirement to fully consider aboriginal foster placement for children in care whether first entering care or subsequent placement. This will include a system to document such consideration". The Director Integrated Practice for the regions reports that regional staff, including the resource teams, met with the Executive Director of the Delegated Aboriginal Agency and "they reviewed the intent, importance and requirement to fully consider Aboriginal foster placements for children in care whether first entering care or subsequent placements. Staff will document all of their considerations for placement in their running records". This meeting took place on Nov. 5, 2008.

Strategy 2 was that "the Director, Integrated Practice will develop and distribute a Practice Advisory to all regional staff confirming the intent, importance and requirement to fully consider aboriginal foster placements for children in care". The Director of Integrated Practice for the region reports that this recommendation was completed on March 23, 2009, with the Practice Advisory being distributed to all (regional) staff by e-mail and posted on the region's intranet site.

Strategy 3 was that "the protocol between the (delegated Aboriginal Agency) and the (Region) will be amended to include a process of reviewing placement requests and for discussing differences with regards to possible placements". The Director of Integrated Practice for the region reports that a meeting occurred on April 7, 2009 and the two groups discussed developing a Terms of Reference for a series of ongoing meetings to assess the effectiveness of the existing protocol and to include a process for reviewing placement requests and discussing differences with regards to possible placements, and to make any needed revisions to the protocol. The group planned a further meeting for the following month.

The second goal was that "decisions for the (MCFD Region) to intervene with children and their families, whether through an investigation, family development response or ongoing involvement, will be informed by a thorough and complete assessment of the family and the presenting issues".

The strategy associated with this goal was for the Director, Integrated Practice to lead discussions on this issue at regularly scheduled Regional Practice Forums. The Director reports that all of the necessary steps of an investigation were reviewed at a regional forum of team leaders on Jan. 21, 2009, and an exercise and discussion occurred, including identification of steps which are often not documented or completed during investigations.

The ministry considers the recommendations resulting from the comprehensive case review to be implemented.

The findings of the Representative for Children and Youth's Investigation, in the next section, differ significantly from those of the ministry's Comprehensive Case Review. The Representative's independent investigation discerned areas of practice that fell below the reasonable standard as well as key issues missed in the internal ministry review of the injury.

Analysis and Recommendations

Interviews and documentary evidence form the basis of an RCY Investigation, which considers policies, practices and organization of services to children and families. Analysis of this kind of information is at the core of understanding the system of supports and services to vulnerable children, and understanding how the system works and doesn't work in promoting positive outcomes for children.

In the course of conducting an investigation, the Representative may find there were errors or misjudgments (by individuals or organizations) that created conditions that were unsafe or unsupportive. The Representative's role is not to find fault or attribute blame. It is to conduct careful and thoughtful systemic analysis, to report on observed facts, and identify and recommend measures that will provide optimal safety and development for vulnerable children. As noted earlier, the expected standard of practice is that of a reasonable practitioner, trained and familiar with existing legislation, policy and standards in place at the time.

Where the immediate cause of injury is not clear, there will be cases where the Representative will be required to make a finding regarding the precise mechanism of that injury. In that situation, the purpose would not be to find legal fault but to make it possible to realistically determine what the child-serving system may have done to prevent it.

There is obviously a question as to whether the injury to this child was intentional, accidental or independent of anything caused by the foster parent. For the purposes of this investigation, it is not necessary for the Representative to make a definitive finding on this issue. As indicated below, there are no known issues in the history or immediate circumstances surrounding the foster placement. While the question of intentional injury has been considered throughout all the investigations and proceedings, the precise timing and cause are matters of conflicting and diverging stories and expert opinion. The Representative is not in a position to make full findings of credibility and weigh the preferred evidence. This must be left to a civil court for full judicial determination on the proper tests.

The child who is the focus of the present investigation was an infant of a few months of age at the time he was removed from the care of his parents. His developmental needs were to be nurtured and nourished and protected from harm; he was completely dependent on the adults in his life to provide for all of his needs. The Representative encourages that this perspective be kept clearly in focus in considering the issues in the Overall Finding section.

Overall Finding

The system of supports and services failed this baby, and fell below the prescribed standards. This was not only the result of practice issues. It was also a failure to look at all of the issues in a young family's life and offer service that would provide an appropriate and even common sense response to those issues.

The child welfare system entered into this child's life in response to child protection reports from the community, but its ongoing impact on the child's life related to his parent's poverty and inability to afford housing that met the ministry's standards. They were young First Nations parents who wanted to live close to their family and culture for the benefit of their new baby. The available housing was either well outside of their financial means, or with relatives who were persons of concern or who lived off-reserve.

Many service providers from at least three MCFD offices, a delegated Aboriginal Agency, a contracted family service agency, and MEIA (now MHSD) were involved in the five months from when the first report was made to when this child was removed from the care of his parents to the time of the injury. However, it wasn't until the baby had been in care for two months and was already in his second foster home that practical assistance from a contracted services agency was put into place.

The system was not flexible and responsive in addressing the root problem faced by this young family, which was a practical issue of short-term money for housing, not a clinical issue. As a result, this baby was separated from his parents, his community and his culture. He was critically injured, in unusual or suspicious circumstances.

Poverty and Housing

Finding: *Poverty and lack of affordable housing played a major role in creating the conditions in which this baby was removed from the care of his parents, and insufficient support was provided to this young family.*

Although there were a number of service providers involved over a very short period of time, there was no clear focus on assisting this young family in solving the key problem that prevented them from living with their baby – lack of a safe home.

There was no suggestion that this baby's parents were abusive, or neglectful of his care, or unsafe parents. The child was removed because the parents did not keep him away from relatives considered to be unsafe, and because they did not have a "safe" place to live. Yet they had no realistic alternatives. They were impoverished. Therefore, it is surprising from a common sense perspective that there is no evidence that alternative solutions such as temporary hotel accommodation or an emergency housing grant were considered, even though that would have been less disruptive to the family and less costly than foster care. The life-long cost of caring for this child is unknown.

In 2006, the Hughes Review noted that in B.C. and other jurisdictions, "most child protection cases arise within families that are materially disadvantaged: almost half either are on income assistance at the time when a child is apprehended, or have recently been. Almost half are also Aboriginal although further statistical study shows that among low-income families, child protection reports are no more frequently made about Aboriginal families than about non-Aboriginal families. In other words, the factors that result in child protection cases are closely linked to the social and economic conditions of families and communities."

When the ministry received the first report that the child was living in unsafe circumstances, the child and his parents were living with relatives. The Chief of their First Nation community indicated to the Representative's investigators that there are probably over 200 people on the list for housing on reserve. The Chief also indicated that it was common in their community for different generations to live together in one house, and that many homes accommodated more than a dozen people. This is not by choice, but necessity.

In the course of this investigation, it became abundantly clear that in this First Nation community, this has become accepted as part of the way things are, and as a practical way of coping with a lack of housing in the absence of any real alternative. The ministry's actions, however, appear to stem from a flawed assumption that Aboriginal parents have alternative housing and accommodation options available to them.

The Representative notes the achievement that this particular First Nation community has made in adding 24 new homes to the housing stock on reserve during the last 1 ½ years. However, given the great demand for housing, a wholesale solution will likely be years in the making.

The Representative believes it is unacceptable that a baby in British Columbia is separated from his parents largely because they are unable to immediately create a living situation that they could not reasonably be expected to achieve in the normal course of events, especially without practical assistance or support to navigate complex systems. This places the basic human rights of children in jeopardy and tears families apart in a tragic way, especially Aboriginal families trying to recover and rebuild while grappling with profound historic and ongoing barriers.

Virtually all front-line service providers told RCY investigators that it would be almost impossible to find suitable accommodation off-reserve in their community for the amount eventually provided by the income assistance shelter allowance. In fact, the general view was that there was a gap of $200 – $400 per month between shelter assistance funds, and what it would cost to rent appropriate accommodation in the nearby community. Income assistance regulations at the time allowed for a crisis supplement to help families cope with unexpected expenses in order to prevent removal of a child. However, the regulation indicates that such a supplement would have to be dealt with monthly, and

does not specifically address ongoing gaps between the allowance and market rents. In any event, this provision was not explored as a possible solution for this family.

In the case of the young parents of the child at the centre of this investigation, suitable, affordable housing was not secured until November 2008. They deserve credit for their determination, but will now care for a developmentally disabled child while continuing to struggle with poverty. The Representative is concerned that their particular struggle may deepen.

Two employment assistance workers were involved in the income assistance application for the child's mother. One worked in the application services department and had telephone contact with the child's mother when she first called to apply for income assistance. The MHSD file information indicated that this worker exempted the child's mother from the requirement to look for work. However, she was still required to undergo the three-week waiting period, despite being at immediate risk of losing custody of her son, coping with the demands of being a new mother and trying to locate an adequate home.

A second employment assistance worker became involved with the child's mother's application on Nov. 2, 2006 when she had in-person contact with the child's mother. This employment assistance worker indicated to the Representative's investigators that she was aware of the barriers that this child's parents were facing. The worker said that in the course of the income assistance application process, an employment assistance worker has significant discretion regarding an individual applicant and can decide whether they will be subject to or excluded from particular requirements in the process. MHSD has clarified that workers don't have discretion per se. Rather, they exercise judgment about whether applicants fall into categories of exemption specified in the Regulations.

At the time that this child was in the care of MCFD, the MEIA income assistance policy required that each new applicant had to undergo a process as described below:

> Currently, applying for income assistance is a two-part process. During the first stage the ministry assesses whether an applicant has to complete a three-week work search before proceeding further with the application or whether the applicant is exempt from that process.
>
> During the initial interview, ministry staff can use an income assistance estimator to calculate the amount of assistance that an individual might receive and provide a preliminary, and non-reviewable, estimate of whether an individual is, or is not, eligible for any assistance. In addition, at several times during the first stage ministry staff provide an applicant with information and on each occasion may ask whether a person still wishes to proceed.
>
> If an applicant is assessed as having an "immediate need" such as having no food, nowhere to live, or is fleeing an abusive relationship, then the ministry

> policy is that the applicant should receive an eligibility interview within one business day of being assessed as having that immediate need. If an applicant is exempt, for one of the other reasons set out in regulation, then an eligibility interview should occur within five business days.
>
> If, however a person is not exempt, he or she is required to complete a three-week work search. It may then take up to a month to complete the entire application process. This normally involves an applicant completing five work search activities a day; accessing and using the ministry's online income assistance estimator to evaluate eligibility; completing, along with other adult members of his or her family, a web-based orientation session; calling back after 14 days to allow an evaluation of whether the job-search requirements have been met; and providing any documentation required by the ministry to assess the applicant's eligibility.... Prior to October 2007, it was up to the person applying for income assistance to raise the issue of any immediate needs....
>
> Ombudsman's Public Report No. 45, March 2009
> *Last Resort: Improving Fairness and Accountability in British Columbia's Income Assistance Program*
> Executive Summary, p. 3

It is clear that decisions around exclusions from other requirements in the process were influenced by the applicant's inability to articulate the urgency of her need to the income assistance workers, and a lack of flexibility in accommodating the emergency needs of a young Aboriginal family.

In the Ombudsman's Public Report No. 45 (2009), the overall process of applying for income assistance in B.C. was described as "unduly complex and not designed to meet the needs of people who are applying for assistance". The report found that the process can "discourage people who are in need from obtaining the assistance available to them." For these young Aboriginal parents, this system was not appropriately responsive to their immediate need for assistance.

The Ombudsman's report noted that MHSD made progress toward simplifying the income assistance application process in the past two years. However, the Ombudsman recommended that MHSD continue to further simplify the process for the benefit of applicants and that the ministry report publicly on its progress.

Later in November 2006, a MHSD (then MEIA) policy directive was issued, which reminded workers of provisions in the Regulations regarding emergency need, and noted that staff should be proactive in determining whether there were emergency needs that the client may have difficulty expressing due to medical or social barriers or lack of knowledge about legislation and policy. In April 2009, a Regulation exempting sole applications with a child under age three from the three-week work search was enacted.

The Representative appreciates ongoing efforts to improve the application process, but is of the view that a clear need remains to address issues such as the circumstances observed in the present case.

Recommendation 1(a):

That MCFD and MHSD work collaboratively to develop a proactive process and explicit policy for front-line staff serving families whose children are at risk of being removed by MCFD due to housing-related issues. The intent should be to avoid such removals whenever possible.

Detail:

The process should have the following characteristics:

- user-friendly for parents living in poverty who have challenges with transportation and child care
- accessible and welcoming for young parents, including those who have been children in care themselves
- sensitive to the poverty and housing dilemmas faced by Aboriginal families
- provide for options that work in different types of communities (urban, rural, remote)
- consistently available in all regions

This mechanism and policy should be in place as soon as possible, and not later than Jan. 1, 2010.

Recommendation 1(b):

That the Government of British Columbia engage the Federal Government and First Nations leadership and communities to develop a plan to reduce Aboriginal child and family poverty in B.C. This plan must include concrete measures and policies, and provide for resources and monitoring of progress.

Detail:

- A first meeting to formulate a plan to be held by Oct. 15, 2009 with a first progress report toward a concrete action plan by March 31, 2010.
- Regular progress reports on the measures taken and progress made, every six months thereafter.

Investigations and Removal

Finding: *The removal of this child from his parents, and the process by which that occurred, was characterized by practice that fell below standards. Child and Family Development Service Standard 18, which requires planning for the child's safety based on identified strengths of the child's family and community, and serious consideration of alternatives, was not met.*

Standard 18 sets out the steps that social workers must take in developing a plan in order to keep a child safe. The standard emphasizes collaboration with the child's family and community members, and the use of services to support and strengthen a family's capacity to care for a child.

Standard 18 identifies strategies a social worker can use to ensure the safety and well-being of a child, including family group conferencing, care agreements, mediation, supervision orders and removing a child from the parental home.

MCFD social workers completed two investigations involving this child. At the conclusion of the first investigation, the social worker determined that it was appropriate to close the file without the need for services. This was despite the worker acknowledging throughout her investigation that the core issue was not one of parenting, but rather the parents' ability to provide a safe place for their child to live. There is no logical explanation on the file as to why services and/or ongoing involvement was not considered given the circumstances of this young family, and given the concern that the safety plan was not being followed. There is also no good explanation for why the ministry closed the first investigation despite the young family living in the same environment that caused the ministry to initially require the parents to move the child out.

The ministry's concerns in the second investigation similarly arose out of the parents' inability to secure housing that would properly address the concern of certain relatives having access to the child.

This child was the first for these young parents, who had recently returned to B.C. from out of province and did not have the financial means to provide for their child. At the time, they were reliant upon financial assistance and facing a dilemma. They could remain on-reserve in their community and receive social assistance from their band, but have to live in a home that MCFD deemed unfit. Or, they could move off-reserve, away from their family and community, look for acceptable housing and after a waiting period, receive government financial assistance. They could anticipate a significant gap between the financial assistance they would receive and the cost of off-reserve housing.

It is clear that the overall circumstances of the child's parents, which ultimately gave rise to the concerns regarding the child's safety, were not fully considered. It is also clear that alternatives to removal were not given appropriate consideration, in accordance with

Child and Family Development Service Standard 19. The standard prescribes that removal of a child from the parental home is to be considered only when the child is in immediate danger, or after fully exploring less disruptive measures. According to the standard, potential strategies include:

- informal and formal support services
- informal kinship care
- voluntary care agreements
- a supervision order without removal

At the conclusion of the second MCFD investigation, the social worker decided that less intrusive measures than removal were not a viable option. A supervision order was not considered an appropriate response to the child protection concerns and the social worker was concerned the parents would not comply with restricting access to the child by certain relatives.

It is notable that members of this child's family and community expressed strong feelings to RCY investigators that there were options available to provide a safe environment for the child, but events unfolded quickly and none of those alternatives were considered or discussed.

The parents of the child chose not to participate in family group conferencing because the ministry had identified certain members of their family as high risk. It was reasonable that the father was unclear about the mixed message he was receiving. On one hand, his child was being removed because his family members posed a risk. On the other hand, they were asked to participate in a conference with these same family members to plan the child's future.

The family group conference, however, could have been adapted to only include other members of the child's family who were not considered a risk to the child, as well as community members of the child's First Nation. In the course of this investigation, the Chief of the child's First Nation said that the ministry had made no effort to include the child's community in planning for the child.

There is no evidence that the ministry followed up or pursued an alternative course of action that could have resulted in creative problem solving. Greater effort should have been made in this case to involve the child's community and other members of his family in a family group conferencing process, which may have resulted in a better plan for the child's involvement with his family.

The process by which this removal was conducted, the lack of planning at the time of the removal and immediately after, was not consistent with Standard 18 and Standard 19.

Planning for the Child

Finding: *The planning for the care of this child was inadequate by all involved and fell below reasonable standards of practice.*

In the approximately five-month time period covered by this investigation, a number of agencies had significant involvement, including at least three separate organizational units of MCFD and at least six front-line ministry staff, a delegated Aboriginal Agency, a contracted family services agency, and a MEIA financial assistance office. There was evidence of numerous meetings among different workers, and overall, each of the providers was clear about their individual roles and responsibilities. However, none of the workers appeared to consider the critical connection between their role and this child's care.

There was a significant lack of overall planning for the child throughout his time in care. The comprehensive risk assessment and risk reduction service plan were completed and identified the family's need to secure suitable housing. The social worker who removed the child testified in court one week after the child's removal that the ministry would consider returning the child to his parents, if they were able to secure suitable housing. However, ministry staff did nothing to assist the child's family in meeting this expectation until the matter was referred to the contracted agency nearly two months after the child had been removed.

The Representative also examined MCFD's audits of practice in this region. In 2006 and 2007, MCFD conducted four Director's Case Practice Audits in the planning area where this child resided while in care. The audits were conducted according to the ministry's internal Case Practice Audit Methodology and Procedures Documents (2003). The stated purpose of ministry audits is to "support practice principles that promote improved outcomes for children and families. Through a review of a sample of cases, case practice audits help to confirm good practice and identify areas where practice requires strengthening."

The audits examined 173 ministry files. Of the 173 files, 23 were open at the time of the audit and 14 were child service files. Supervisors were interviewed with respect to the operation of their offices and some social workers were interviewed regarding overall service delivery.

The audits found between 50 to 84 per cent compliance with ministry standards of practice. Rates of compliance, partial compliance and non-compliance were assessed on the basis of file documentation only.

Standard 1: "Screening and Best Approach to Service Delivery" and Standard 12: "Assessing a Child Protection Report and Determining the Most Appropriate Response" were assessed together. Rates of compliance for these standards ranged from 80.8 to 98.1 per cent.

Two audits found low rates of full compliance (3.7 per cent and 50 per cent) with Children in Care Service Standard 11: "Assessments and Planning for a Child in Care". The standard sets out the requirements for developing a child's plan of care. An initial plan of care is to be completed within a maximum of 30 days of the child coming into the care of the ministry. Initial care plans are to include:

- the long-term goal for the child
- contact with the child's family and community
- the services required to fulfill the plan
- strategies for the child to remain involved in social, recreational and spiritual activities

An initial plan of care was not completed for this child. This means that goals and objectives for the child were not clearly established, and that the services he required while in care were not identified or defined. Plans of care demonstrate that the government takes its fiduciary responsibilities seriously and makes best efforts to address the needs of vulnerable children and youth. Without a plan for the child's care, the needs of this vulnerable infant were not fully addressed.

An MCFD policy document, *Cultural Plan for Aboriginal Children in Care*, sets out the ways to develop a cultural plan for an Aboriginal child and details the involvement of the social worker, the First Nation and/or Aboriginal community and caregivers in such a plan. This policy was in use at the time of the child's removal but was not used to assist with planning for the child's care.

Of note, one of the recommendations made in the MCFD Director's case Practice Audits was: "The [MCFD supervisor] will ensure that the Cultural Plan policy is followed with Aboriginal children in care and will provide strategies for how this recommendation will be met." The recommendation was to be implemented by August 2006. However, no evidence of a cultural plan for the child, who was taken into care in September 2006, was identified in this investigation.

Finding: *There was a two-month delay in a referral from the ministry to a contracted service agency. This delay, as well as a lack of complete information on the referral, did not match the urgency of assisting the parents to meet the requirements necessary in order to be reunited with their baby.*

From the time of the first investigation in July, until after the child was removed from his parents in September, social workers involved with the child and his family made reference to the difficulty the parents were having in their efforts to locate suitable housing.

The comprehensive risk assessment and risk reduction service plan documents also identified accommodation as a critical issue in the ministry's involvement in this child's life. Yet, the referral to assist the family in addressing this critical issue was not made until November, nearly two months after the child was taken into the ministry's care. The reason for the delay is unclear.

When the family service worker received the referral from the MCFD social worker, the referral included minimal information – only a brief outline of the risks that MCFD had identified in the comprehensive risk assessment and risk reduction service plan documents.

The family service worker was not supplied with additional information that would have provided a context in which to understand the child and the child's parent's lives more clearly. The family service worker reported that additional information is generally not supplied to that particular contracted agency and that ministry social workers cite confidentiality as the reason.

The ministry has a protocol in place with the contracted family service agency which directs the MCFD social worker and family service worker to meet when the ministry makes a referral to the agency, to review documentation, discuss the family's involvement with MCFD and develop a case plan. While the ministry indicates that it disagrees with this assessment, it is the Representative's view that the requirements of the protocol were not followed by the MCFD social worker in this case, and the family service worker did not receive all relevant information.

Finding: *At the time of this child's involvement with the ministry, collaboration among the ministry, the delegated Aboriginal Agency and the First Nation was far from optimal and the service responsibilities were not clear.*

Improved collaboration among the ministry, the delegated Aboriginal Agency, and the First Nation is required to stay focused on the child and realize the intent of Sections 3(b) and 71 of the *CFCS Act* and the terms of both the Delegation Agreement and AOPSI. While MCFD asserts that Section 71 of the *CFCS Act* is not applicable to the actions of the Agency in this case, it is nonetheless incumbent on the ministry to work with the Agency in fulfilling the placement criteria in Section 71.

The Chief of the First Nation expressed the view to RCY investigators that the ministry must develop the practice of speaking with the band and problem-solving in the interests of the child before a removal takes place. The viewpoint is that once a removal occurs and the court process begins, it becomes increasingly difficult to return a child or put in place other alternatives to foster care.

In 2002, the ministry entered into a Delegation Agreement with the delegated Aboriginal Agency (created by nine member First Nations) and the federal government. This Agreement and accompanying Protocol document are silent regarding two matters that the Representative regards as being essential to ensure that child protection policy is properly carried out in emergent situations involving the removal of a child from a reserve community.

The first is the lack of clarity regarding how placement decisions are made and carried out when a child is removed by the ministry. The Agreement suggests that the delegated Aboriginal Agency must develop residential resources, provide support services and work with families, but neither the Agency nor the ministry acted as if that was the case in this child's situation. The purpose of delegating this role to the Agency in the first place is to provide the maximum opportunity to ensure that Section 71 of the *CFCS Act* is respected and that Aboriginal children are not subject to removal from their family and community unless all other less intrusive measures will not be effective at protecting the child.

In this case, an opportunity to place the child in a First Nations foster home may have been lost due to a lack of clarity in roles, and an operating assumption that when the ministry removes the child, the ministry is solely responsible for decisions regarding placement and the Agency plays no part.

The second important area where the Agreement is silent concerns the role of an Agency to effectively utilize and mobilize the resources conferred under the Agreement to identify, nurture and develop resources that will enable children who are removed to remain connected to their Aboriginal communities. Surely the reason Agencies are expected to develop residential resources (such as individual foster homes or group homes) is so that those resources can be used to place children who cannot remain in their parents' care.

While the Agreement is strong on listing delegations and administrative responsibilities, it is conspicuously silent on the delegated Aboriginal Agency's obligations to take concrete steps necessary to ensure that they can exercise their delegated powers and AOPSI commitments effectively. When a child has been removed from a reserve, an Agency must play an important role in giving advice and making proposals for the prompt return of the child to his or her Aboriginal community. It is not clear that either of these functions were operating effectively in 2006.

In April 2009, a new Delegation Agreement was signed with this Agency. It does not address the concerns addressed above. One month earlier (March 2009), the ministry issued a Practice Advisory reiterating the requirements of Section 71 of the CFCS Act and requiring ministry social workers to consult with family and Aboriginal organizations regarding potential Aboriginal foster placements. While the Practice Advisory is helpful for ministry staff, it assumes that the decision-making lies exclusively with the ministry. This is puzzling and suggests the ministry has not provided clarity in the Agreements. The Practice Advisory does not address the issues raised above regarding the roles and responsibilities of the delegated Aboriginal Agency both before and after a child is removed.

If legislative and policy requirements are to be fully realized in B.C. these are matters requiring urgent clarification and further ongoing work as the participation of Aboriginal communities in child welfare continues to develop, and as delegated Aboriginal Agencies assume responsibility for child protection services.

While the Agreement emphasizes that an Agency exercising delegated authority is acting and is required to act solely in the interests of the child – that there be a "separation of the delegate role from the role of aboriginal community" – a tendency can arise for the ministry to have the perspective that in dealing with the Agency, it is dealing with the First Nation. However, that is clearly not the case. Over time, it is unavoidable that some actions of the delegated Aboriginal Agency may be as alienating to an individual First Nation as the ministry's actions were in the case of the removal of this child from his family.

In April 2008, the First Nation hired a social worker who is very experienced in child welfare. The role she plays is to advocate for band members and to help them access needed resources. This is a strength, but it is not clear why another layer of service is necessary and if the duplication of roles will confuse or clarify the existing Delegation Agreement between the First Nation and the Agency.

Within the past few months, MCFD has established a position on its Aboriginal Services team in this particular community to focus on arranging supports and interventions on a preventive basis to mitigate risks and reduce the need for removals of children. However, given the absence of an overall practice framework supporting this as an approach of choice, the impact of adding one position is unlikely to have a significant overall impact. For a wide range of issues, including housing, cultural planning, comprehensive care planning and family supports, the practical duties and accountabilities are far from clear and direction at the front line in practice uneven. This coupled with gaps in the Delegation Agreement poses a risk to service to vulnerable Aboriginal families.

The Representative recognizes the efforts of the child's First Nation and the ministry to take a proactive approach to improving collaboration and service delivery, and encourages them to continue to evaluate and review efforts to better meet the needs of vulnerable children. However, the Representative notes that there is no practice framework to support or provide practical direction in implementing collaboration or in realizing the outcomes that protocols are intended to achieve.

The Representative believes that it is critical at this time in the evolution of child welfare services that there be a full examination of how the principle articulated in Section 3(b) of the *CFCS Act*, that "aboriginal people should be involved in the planning and delivery of services to aboriginal families and children" is given life. In this context, it means that there be a clear understanding among the ministry, the delegated Aboriginal Agency, the First Nation, and Indian and Northern Affairs Canada about the nature and extent of consultation and participation in decision-making in child welfare matters.

The Hughes Review identified that issues of jurisdiction and funding between the federal and provincial government need to be clarified and practice issues improved. To date, there appears to be no or limited progress on this matter. The Representative urges all parties to return to substantive discussions on this issue.

It is vital that all parties understand and discharge their roles and joint authority for the safety and well-being of Aboriginal children and youth. The existing legislative provisions are available and viable. The capability to achieve the standards for practice is sometimes hindered by political and economic arguments as well as inattention to practice details as noted above. The responsibility of all must be to ensure that the rights and safety of Aboriginal children are focal points and paramount.

Recommendation 2:

That MCFD work in consultation with the delegated Aboriginal Agency, the child's First Nation, and Indian and Northern Affairs Canada, to ensure that Sections 3(b) and 71 of the *CFCS Act* are fully realized, and that the purpose and intent of the Delegation Confirmation Agreement are fulfilled.

This will require clarifying the nature and extent of consultation and participation expected of each party in child welfare matters, and amending Delegation Confirmation Agreements to reflect this understanding.

Detail:

- A progress update should be provided, in writing, to the Representative by Jan. 1, 2010.
- Required amendments should be made to practice standards or advisories, and protocols by Jan. 1, 2010.
- Front-line staff and supervisors should be fully trained by April 1, 2010.
- The outcome of this work should be formally shared with ministry staff, other delegated agencies and First Nations across B.C.

Foster Care

Foster care providers play a key role in society through support for some of society's most vulnerable young citizens. The Hughes Review called foster parents "the backbone of a child-serving system". Being a foster parent can mean offering hope to those without hope. Often the needs of these children can vary widely and foster caregivers must be prepared to meet the needs of each individual child, at times with little notice.

Finding: *Despite the overall finding that the removal of this child was not the least intrusive approach to protect the safety of the infant, legislative provisions and service standards were not met in the placement of this child. Serious and sustained efforts were not made to find a foster home connected to this child's cultural identity, and respect his right to maintain his connection to this culture. In addition, few Aboriginal foster home alternatives were available. The delegated Aboriginal Agency role was not clear.*

On the same day of this Aboriginal child's removal from his parent's care, the ministry placed him in a home with experienced, reputable foster caregivers. However, it was not an Aboriginal foster home. There is conflicting evidence about what efforts were made by ministry social workers to locate an Aboriginal foster home for this child.

According to the investigating social worker, two potential caregivers from the child's community were contacted immediately after the removal but no response was received back from these individuals. The child's parents said these individuals were not contacted by the ministry. This investigation did not resolve this conflicting information.

Section 71(3) of the *CFCS Act* provides that when placing an Aboriginal child out of his or her parental home, priority must be given to placing the child as follows:

(a) with the child's extended family or within the child's aboriginal cultural community;

(b) with another aboriginal family, if the child cannot be safely placed under paragraph (a);

(c) in accordance with subsection (2), if the child cannot be safely placed under paragraph (a) or (b) of this subsection.

The ministry's Child and Family Development Services Standard 20: "Placements When a Child Comes Into Care" states:

> if the child is Aboriginal, work in partnership with the involved Aboriginal community or identified Delegated Agency to choose a caregiver for the child. Consider all adult members of the child's extended family or other persons within the Aboriginal community as possible caregivers for the child. Actively follow up with suggested or recommended members of the child's family or community to determine whether they are willing or able to care for the child.

A potential resource identified by the delegated Aboriginal Agency was rejected by the supervisor of the resources team because of the inexperience of the foster parent, whose home had previously only been approved as a Restricted foster home.

The ministry reported that at the time there were 110 non-Aboriginal foster homes in the planning area where this child resided and five Aboriginal foster homes. All of the Aboriginal homes were Restricted foster homes.

The ministry's Caregiver Support Service Standards came into effect one week prior to the child's placement in the third foster home on Dec. 12, 2006. The stated purpose of the Caregiver Support Service Standards is "to promote and enhance the safety and well-being of children in care by providing caregivers with high-quality services throughout the caregiving process."

Two of these standards are of direct relevance to the placement decisions.

Caregiver Support Service Standard 12 states that wherever possible, the ministry should work with a child's family and community when making decisions regarding where the child will reside while in care. The standard stresses the use of collaborative practice between the child's social worker, caregiver and community in order to support a strong and stable environment for the child.

Caregiver Support Service Standard 10 sets out the requirements for the ministry to locate suitable Aboriginal caregivers for children in care. The standard emphasizes cooperation between the child's community and the Aboriginal delegated agency in locating an appropriate placement for the child that is from within the child's Aboriginal or First Nations community.

When the child was moved to a second foster home, and then a third, there were no efforts taking place to locate an Aboriginal foster home for him, or a foster home on his reserve. The caregivers who fostered the child in his second placement identified as Métis and the resource worker said they were considered an Aboriginal foster home.

The fact that there were few Aboriginal foster homes at the time does not excuse efforts to canvass all available options, and is, in itself, a systemic issue that subverts legislation, policy and standards. The goal is to ensure that a child can stay within his distinct culture, language and traditions.

As a result of the recommendations in the ministry's internal review, the MCFD region with jurisdiction in this case issued a practice advisory (next page) to staff in March 2009 regarding placements of Aboriginal children in care. Advisories do not have the force of formal policy or standards, they are not consistently applied or tested for compliance, and their actual impact on day-to-day practice is uncertain. Although the ministry is of the view that the practice advisory is consistent with the Delegation Agreement, the Representative is of the view that it is not.

MCFD Practice Advisory (March 2009)

Whenever a placement is needed for an Aboriginal child the Social Worker / Ministry worker will:

- ask the child's parents and extended family for possible placement options for the child
- consult all protocols with the child's Nation and/or the appropriate local Aboriginal organizations
- contact the child's Nation or the appropriate local Aboriginal organization and request assistance in identifying possible caregivers
- consider the use of family group conferencing or traditional dispute resolution process in order to locate a possible resource
- discuss with the local Resource Team, the child's Nation, and the appropriate local Aboriginal organization how each suggested placement could be supported to provide a home for an Aboriginal child in care
- document all attempts to locate a possible home and the rationale for denying or accepting each placement option.

The Hughes Review urged the ministry to develop performance measures, improved information management systems and measurements of success for placements of Aboriginal children in care with Aboriginal caregivers. It is unclear how much progress has been made on this issue, as the existing ministry information system cannot accurately capture this information. The Representative has been advised that a new information system is under active development and will be implemented over the next 18-24 months.

The Representative feels strongly that before and after removing a child from a parental home, every effort should be made to engage in creative problem solving with the child's family and community members, as set out in the CFCS practice standards developed by the ministry.

Caregiver Support Service Standard 4 sets out the requirements for strategies of recruiting Aboriginal caregivers, as determined by the needs of a particular community. The standard emphasizes consideration of the unique cultural and community values within Aboriginal and First Nations communities and states that recruitment and assessment strategies be developed in partnership with the delegated Aboriginal Agency and First Nations community.

The over-representation of Aboriginal children in care highlights the importance of having an adequate number of foster homes available for vulnerable children and youth, from within their own community. In this investigation, several individuals noted that some of

the ministry's standards relating to foster homes or foster parents present barriers to Aboriginal people. One example of this is standards about space and bedrooms in a foster home. What might be 'below the policy standard' of the ministry may be the cultural norm or even a preferred option in an Aboriginal home or community.

Ways must be found to ensure that Aboriginal people who can provide safe and caring foster homes for Aboriginal children are not unnecessarily excluded. The answer is not to arbitrarily lower standards or place Aboriginal children in unsafe homes. The objective is to ensure that Aboriginal children in foster care reside in homes within their cultural communities that are safe and can meet their needs. Through this lens, a full consideration of standards and examination of constructive ways to remove barriers is essential.

Recommendation 3(a):

That MCFD, working with the delegated Agencies and partners in Aboriginal child welfare, including the Federation of Aboriginal Foster Parents, develop and implement an aggressive strategy throughout the province to recruit, assess, qualify, retain and monitor Aboriginal foster homes.

Detail:

- The system of qualifying prospective foster parents should be reviewed to ensure that there are no systemic biases.
- The strategy should incorporate measures to inhibit over-allocation of children to new or existing homes.
- The strategy should include methods to measure and report on progress and challenges.
- The strategy should be fully implemented by April 1, 2010.
- The recruitment should attract foster parents from First Nations with children in care, to ensure cultural and linguistic continuity for the child.

Recommendation 3(b):

That MCFD, starting with this region as a model and eventually province-wide, develop a routine mechanism for tracking and reporting on efforts to find Aboriginal placements for each Aboriginal child that comes into care. Such recording and reporting is necessary to be able to demonstrate improvement over time.

Detail:

- Tracking to include maintenance of cultural continuity and match between cultural identity of child and caregiver.
- Public reporting to occur semi-annually.
- Reporting should include information on resources that become inactive or delisted.
- The mechanism to be in place in this region by April 1, 2010.

Conclusion

The foundation that this report is built on is the Representative's investigation into a truly sad and tragic event – the critical injury of a First Nations infant who was in the care of government. A profound sense of sadness is felt for the family, for the community, and most deeply for the child whose future has so drastically changed.

We fail if we do not learn all that we can from the circumstances around such events. The Hughes Review noted that because critical injuries occur more often than child deaths, they are "a better indicator of needed change." He went on to note that in combination with looking at these injuries, "an ongoing program of needs analysis, and evaluation of the results of interventions with children and families" is required.

The Representative does this by moving from the specifics of one child's injury to a bigger-picture examination of present day practices. Knowledge from the investigation is combined with lessons learned from past RCY reports, and from about 3,000 advocacy cases the Representative's office has taken on to date. This work allows the Representative, as the Hughes Review says, to "identify and analyze trends that will inform improvements to the child welfare system as well as broader public policy initiatives."

The Representative respectfully requests that the Deputy Ministers of the two key ministries (MCFD and MHSD) distribute this report to front-line workers across the province. Essential learning can take place if front-line workers are encouraged to reflect on the practice challenges and barriers identified in this report, and consider how these relate to their own current caseloads and future practice. The Representative makes this request because unfortunately, at this time, there is no formal linking between findings in the Representative's reports and training or information-sharing out to ministry staff. Change that results from individual reflection and learning can profoundly improve the lives of vulnerable families.

Our collective responsibility for the safety and well-being of children – Aboriginal and non-Aboriginal – cannot be divested, for any reason. Nor can that responsibility be left in the hands of those who do not accept, understand or take seriously the full range of accountability for their actions. Agreements cannot be left unclear, and practice must not fall below standard.

Whenever the government or its agents step into the lives of families, they must do so for the right reasons and with the right tools. A vital element in safeguarding children and youth is that strong internal and external accountability mechanisms exist, which allow the child-serving system to measure its performance, assess its strengths and weaknesses, and adjust accordingly.

If critical injuries of children in care can be prevented, we must do all that is possible. This includes asking difficult questions that we as a society too often shy away from discussing in a frank and candid manner. One of these is the extent to which we consider problems in Aboriginal communities to have been solved by transferring responsibility to those communities, without addressing the underlying systemic challenges of poverty and exclusion.

The Hughes Review noted that transferring child welfare governance to Aboriginal authorities is controversial. "It is energetically supported by some. Others fear that the level of responsibility could be overwhelming, at least in the foreseeable future, when their communities face so many other challenges as well."

When we transfer responsibility without ensuring adequate capacity, service quality or resources, we run a significant risk of seeing a standard of care and safety that is simply unacceptable. When we fail to adequately monitor the practice in such situations, we all become complicit in the tragedies that occur.

Protecting the rights and safety of children is not all about the governance structure, nor is it all about issues of jurisdiction. It is about people of good will – with skills and abilities that match their responsibilities – coming together with a common purpose and using all their resources to support a family and/or a child in distress.

In the course of this investigation and through the advocacy and review functions of the office, the Representative has identified a number of concerns about the quality assurance of the foster care system in British Columbia.

Given the very important role of foster parents and the equally important role of a strong and objective quality assurance process for them, the functions of recruitment, selection, support and review must be of the highest calibre. The Representative will continue to monitor and comment on the system of out-of-home care but also recommends to MCFD that it comprehensively review foster care. The last major review of the system took place in 1997 and many of the issues identified then are still issues today.

In closing, the Representative returns again to the major finding of this report. This child should not have come into care when other less intrusive options were open, and these options were the preferred and prescribed practice. Immediate income assistance support, a short-term housing grant and positive supports would have been a sensible and appropriate approach under existing legislation, policy and standards for young Aboriginal parents willing to and capable of caring for their infant son. British Columbia lost a chance to help these parents nurture and care for their infant, and events unfolded both dreadful and injurious.

It is inspiring, impressive and to their immense credit that this child's young parents stayed strong through this ordeal, rose above and have had their son returned to their care. Their task will now be to care for him into an uncertain future of lifelong supports, and their road ahead as parents will be more difficult. To create a different and better future for other vulnerable B.C. families, we must ensure they receive the housing, help and hope they deserve.

Glossary

Child in care: any child under 19 years of age living under the custody, care or guardianship of a Director under the *Child, Family and Community Service Act.*

Child protection report: a report received about a child's need for protection due to abuse or neglect. Every report received is assessed to determine the most appropriate response. Responses include: taking no further action, referring the family to support services, providing a family development response, providing a youth response if the child is a youth or conducting a child protection investigation.

Child protection investigation: a process of inquiring into or tracing through inquiry, collection of information, and interviews with parents, teachers, daycare providers, public health nurses, physicians, and extended family members to evaluate whether a child is in need of protection.

Child protection social worker: collects information, responds to child protection reports, conducts child protection investigations, removes children, attends court and works with families to plan for the return of children or for continuing custody.

Comprehensive Case Review: a comprehensive internal review conducted by MCFD that involves the examination of case files as well as interviews of relevant staff, caregivers and service providers. The decision to conduct a Director's case review is based on the severity of the occurrence, the potential link between case practice and outcome, and the level of response required for public accountability.

Comprehensive Risk Assessment: a process and document that describe the risk of harm to a child and the mitigating strengths of the family. Risk assessment includes a review of previous child protection reports regarding the family, identification of risk factors and the potential for future harm to the child. A comprehensive risk assessment is completed whenever a child is found in need of protection.

Delegated Aboriginal Agency: through delegation agreements, the Provincial Director of Child Protection (the Director) gives authority to Aboriginal agencies, and their employees, to undertake administration of all or parts of the *Child, Family and Community Service Act* (*CFCSA*). The amount of responsibility undertaken by each agency is the result of negotiations between the ministry and the Aboriginal community served by the agency, and the level of delegation provided by the Director.

Family service file: the MCFD legal record of services provided to a family through the *Child, Family and Community Service Act* and *Adoption Act.*

Family service worker: a worker responsible for providing ongoing family support to the child and family after an initial investigation or assessment of harm is completed. Typically family service workers work for community agencies that provide services to MCFD by contract.

Foster care: a form of substitute care for children who have been removed from their own homes. This is usually a temporary arrangement, lasting until a child can return home or a family plan for caring for the child can be made. In some situations the child is in foster home until the age of majority (19 in B.C.). Effective foster care ideally includes services for the child, natural parents and foster parents, and periodic review of the placement. Service expectations are guided by the Caregiver Support Service Standards. The foster home program is organized into different levels reflecting the skills and abilities of the foster parent, who is an independent contractor. Foster homes are managed through local ministry offices by a resource team.

Home study: an assessment process that all prospective foster parents are required to complete, to be approved as a foster home. As part of the process, prospective foster parents must have: medical assessment completed by their physician, criminal record checks, criminal records review, references and assessment interviews conducted by a social worker.

Hughes Review (The BC Children and Youth Review): the 2006 independent review of British Columbia's child protection system by the Hon. Ted Hughes, QC. It was this review that recommended the appointment of an independent Representative for Children and Youth.

Intake: the process by which cases are introduced into an agency office. Workers are assigned the role of intake worker to receive phone calls or interview persons seeking help in order to determine the nature and extent of the problems.

MCFD Aboriginal Family Services Team: an MCFD team that specializes in providing services to Aboriginal people within a geographic area. Such teams may be composed of child protection, probation and mental health workers. Not all members of the team may be Aboriginal.

Resource social worker: responsible for the recruitment, retention and on-going supervision of foster homes, group homes and other residential and non-residential services, and for arranging placements for individual children.

Restricted foster homes: a family approved by MCFD to provide care for a child in care who is known or related to them. Most commonly the caregivers are members of the child's extended family. This type of family care home has been recruited because of their connection to the child concerned and is only available for a specific child or sibling group.

Risk Reduction Service Plan: a portion of a service plan that outlines how specific risks to the child will be addressed and reduced.

Supervision order: a court order returning or placing a child in the custody of a parent or other person under specific conditions for a prescribed period of time.

Appendix A: Representative for Children and Youth Act

Section 12 of the *Representative for Children and Youth Act* (2006) authorizes the Representative for Children and Youth to conduct reviews of critical injuries and deaths of children in care or receiving services from the Ministry of Children and Family Development. Section 15 authorizes the establishment of a Multidisciplinary Team to provide advice respecting reviews and investigations.

Investigations of critical injuries and deaths

12 (1) The representative may investigate the critical injury or death of a child if, after the completion of a review of the critical injury or death of the child under section 11, the representative determines that

(a) the reviewable service or the policies or practices of the ministry or other public body responsible for the provision of the reviewable service may have contributed to the critical injury or death, and

(b) the critical injury or death

i) was, or may have been, due to one or more of the circumstances set out in section 13 (1) of the *Child, Family and Community Service Act*,

(ii) occurred, in the opinion of the representative, in unusual or suspicious circumstances, or

(iii) was, or may have been, self-inflicted or inflicted by another person.

(2) The standing committee may refer to the representative for investigation the critical injury or death of a child.

(3) After receiving a referral under subsection (2), the representative

(a) may investigate the critical injury or death of the child, and

(b) if the representative decides not to investigate, must provide to the standing committee a report of the reasons the representative did not investigate.

Multidisciplinary team

15 In accordance with the regulations, the representative may establish and appoint the members of a multidisciplinary team to provide advice and guidance to the representative respecting the reviews and investigations of critical injuries and deaths of children conducted under this Part.

Appendix B: Documents Reviewed During the Representative's Investigation

MCFD Records

- The child's child services file, Volumes 1-5
- The mother's family services file, Volumes 1-6
- The mother's child services file, Volume 1
- The ministry's provincial office file, Volumes 1-4
- The ministry's resource file for the foster home
- Court transcripts
- The ministry's regional office file

Police Records

- RCMP file, Volumes 1-3

Medical Records

- Local hospital records for the child
- Child Development Centre records for the child
- Queen Alexandra Centre for Children's Health records for the child
- BC Children's Hospital records for the child

MHSD Records

- The mother's income assistance file

MCFD Legislation, Policy and Standards Documents

- Aboriginal Operational and Practice Standards and Indicators (AOPSI), October 1999
- Child, Family and Community Service Act (1996)
- MCFD (n.d.). *The Delegation Process.* Retrieved February 2, 2009 from www.mcf.gov.bc.ca/about_us/aboriginal/delegated/delegation_process.htm
- MCFD referral for a family service worker to the contracted agency
- MCFD Cultural Plan for Aboriginal Children in Care, May 2004
- Child and Family Development Service Standards: Child and Family Service Standards, November 2003

- Child and Family Development Service Standards: Caregiver Support Service Standards, December 2006
- Child and Family Development Service Standards: Children in Care Standards, November 2003
- MCFD Family Group Conferencing Reference Guide (2005)
- MCFD Regional Practice Advisory (2009)

MHSD Legislation, Policy and Standards Documents

- Policy Directive, November 2006
- Employment and Assistance Regs s.4.1 and s.4.2

MCFD Protocols and Agreements

- MCFD Protocol with the delegated Aboriginal Agency, February 2008
- MCFD Protocol with the contracted agency, November 9, 2006
- Delegation Confirmation Agreement between the delegated Aboriginal Agency, MCFD and Indian and Northern Affairs (INAC), October 2002 and April 2009

MCFD Reports

- MCFD Director's Case Practice Audit Report, April 2006
- MCFD Director's Case Practice Audit Report, April 2006
- MCFD Director's Case Practice Audit Report, December 2006
- MCFD Director's Case Practice Audit Report, January 2007

Other Material References

British Columbia Ombudsman. (2009). *Last Resort: Improving Fairness and Accountability in British Columbia's Income Assistance Program* (Public Report No. 45 to the Legislative Assembly of British Columbia). Victoria, BC: Queen's Printer.

British Columbia, Representative for Children and Youth. *Amanda, Savannah, Rowen and Serena: From Loss to Learning.* April 2008. Victoria, B.C

Hughes, E. N. *BC Children and Youth Review: An Independent Review of BC's Child Protection System.* April 2006. Victoria, B.C.

National Centre on Shaken Baby Syndrome (n.d.) Retrieved April 10, 2009 from www.dontshake.org

Representative for Children and Youth Act. (2006). Victoria, BC: Queen's Printer

Appendix C: Interviews Conducted During the Representative's Investigation

- Mother and father of the child
- Chief of the First Nation
- Health Administrator of the First Nation
- Cultural Coordinator/Elected Council Member of the First Nation
- Social worker and band designate of the First Nation
- Director, Integrated Practice for the MCFD Region
- Two MCFD child protection workers
- MCFD social worker, Aboriginal Family Service Team
- MCFD Resource worker
- MCFD District Supervisor, Resources
- Delegated Aboriginal Agency Executive Director
- Delegated Aboriginal Agency social worker
- Contracted services agency, family services worker
- MHSD Employment Assistance Worker
- MHSD Program and Policy Implementation Manager
- Foster parents for the child, third foster home

Appendix D: Multidisciplinary Team

Under Part 4 of the *Representative for Children and Youth Act* (see Appendix A: Representative for Children and Youth Act) the Representative is responsible for investigating critical injuries and deaths of children who have received reviewable services from the Ministry for Children and Family Development (MCFD) within the 12 months before the injury or death. The Act provides for the appointment of a Multidisciplinary Team to assist in this function, and a Regulation outlines the terms of appointment of members of the Team.

The purpose of the Multidisciplinary Team is to support the Representative's Investigations and Review program, providing guidance, expertise and consultation in analyzing data resulting from investigation and reviews of injuries and deaths of children who fall within the mandate of the Office, and formulating recommendations for improvements to child-serving systems for the Representative to consider. The overall goal is prevention of injuries and deaths through the study of how and why children are injured or die and the impact of service delivery on the events leading up to the critical incident. Members meet at least quarterly.

The Multidisciplinary Team brings together expertise from the following areas and organizations:

- Ministry of Children and Family Development, Child Protection
- policing
- Coroners Service
- BC Injury Research Prevention Unit
- Aboriginal community
- pediatric medicine and child maltreatment/child protection specialization
- nursing
- education
- pathology
- special needs and development disabilities
- public health

Multidisciplinary Team Members

Dr. Evan Adams – Dr. Adams is the Aboriginal Health Physician Advisor for the Office of the Provincial Health Officer, as well as a family physician. He is a Masters candidate at the Johns Hopkins Bloomberg School of Public Health, a past-president of the Rediscovery International Foundation, and a Youth Advisory Committee member at the Vancouver Foundation. He is a member of the Coast Salish Sliammon First Nation.

Dr. Geoff Appleton – Dr. Appleton is Past-President of the BC Medical Association and an established family physician in Terrace. A significant part of his practice involves the medical care of children and youth, including those of Aboriginal descent. He also served as the Medical Director of the Terrace Child Development Centre for many years, and has expertise in working with children and youth with developmental disabilities and fetal alcohol spectrum disorder.

Karen Blackman – Ms Blackman is currently the Senior Director of Practice Support and Quality Assurance with the Ministry of Children and Family Development. She has 21 years of experience including work as a social worker, team leader, practice analyst and community services manager in the ministry. Ms Blackman holds a Bachelor of Social Work degree and a Master of Arts in Leadership and Training.

Beverley Clifton Percival – Ms Percival is from the Gitxsan Nation, and is a negotiator with the Gitxsan Hereditary Chief's Office in Hazelton. She holds a degree in Anthropology and Sociology and is currently completing a Master of Arts degree at UNBC in First Nations Language and Territory. Ms Percival has worked as a researcher, museum curator, instructor at the college and university level.

Les Dukowski – Mr. Dukowski is a past-president of the B.C. Principals' and Vice-Principals' Association. He has taught for a total of 34 years, 22 of which have been as a school principal or vice-principal. Mr. Dukowski has coauthored a mathematics textbook series and contributed to the 1988 Sullivan Royal Commission on Education.

Ruby Fraser – Ms Fraser is Regional Director, Quality and Risk Management for the Northern Health Authority, monitoring health care incidents across the continuum from community to acute care.

Dr. Jean Hlady – Dr. Hlady is a clinical professor in the Department of Pediatrics at the University of British Columbia's Faculty of Medicine. She is also a practising pediatrician at BC Children's Hospital and has been the Director of the Child Protection Service Unit for 21 years, providing comprehensive assessments of children in cases of suspected abuse or neglect. Dr. Hlady also served on the Multidisciplinary Team for the Children's Commission.

Norm Leibel – Mr. Leibel is the Deputy Chief Coroner for the BC Coroners Service, who has 25 years of policing experience and 17 years as a coroner. Mr. Leibel has examined the circumstances around child deaths in criminal and non-criminal settings, with the goal of preventing similar deaths in similar circumstances in the future. Mr. Leibel was a member of the Multidisciplinary Team for the Children's Commission.

Sharron Lyons – With 32 years in the field of pediatric nursing, Ms Lyons currently works as a Registered Nurse at the BC Children's Hospital, is past-president and current treasurer of the Emergency Nurses Group of BC, and is an instructor in the provincial Pediatric Emergency Nursing program. Her professional focus has been the assessment and treatment of ill or injured children. She has also contributed to the development of effective child safety programs for organizations like the BC Crime Prevention Association, the Youth Against Violence Line, the Block Parent Program of Canada and the BC Block Parent Society.

Russ Nash – Mr. Nash is currently the Officer-in-Charge of a Major Crime Section with the RCMP. He has expertise in extensive criminal investigations and, in particular, in homicide investigations. He has been involved in a variety of RCMP programs focused on youth, including the D.A.R.E. program, and also volunteers as a coach and manager of youth sports teams.

Dr. Ian Pike – Dr. Pike is the Director of the BC Injury Research and Prevention Unit and an Assistant Professor in the Department of Pediatrics in the Faculty of Medicine at the University of British Columbia. His work has been focused on the trends and prevention of unintentional and intentional injury among children and youth.

Dr. Dan Straathof – Dr. Straathof is a forensic pathologist and an expert in the identification, documentation and interpretation of disease and injury to the human body. He is a member of the medical staff at the Royal Columbian Hospital, consults for the BC Children's Hospital, and assists the BC Coroners service on an ongoing basis.

REPRESENTATIVE FOR
CHILDREN AND YOUTH

Contact Information

Phone

In Victoria: 250-356-6710
Elsewhere in B.C.: 1-800-476-3933

E-mail

rcy@rcybc.ca

Fax

Victoria: 250-356-0837
Prince George: 250-561-4624
Burnaby: 604-775-3205

Mail

PO Box 9207 St. Prov Govt
Victoria BC V8W 9J1

Offices

Victoria
Suite 201, 546 Yates
Victoria, BC
V8W 1K8

Prince George
1475 10th Avenue
Prince George, BC
V2L 2L2

Lower Mainland
M12-4277 Kingsway
Burnaby, BC
V5H 3Z2

Website

www.rcybc.ca

REPRESENTATIVE FOR
CHILDREN AND YOUTH